SAN BERNARDINO COUNTY | Behavioral Health

Cultural Competency Plan Update
Fiscal Year 2024/2025

San Bernardino County Department of Behavioral Health
Office of Equity and Inclusion

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NONDISCRIMINATION NOTICE

Discrimination is against the law. San Bernardino County Department of Behavioral Health follows State and Federal civil rights laws. San Bernardino County Department of Behavioral Health does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

San Bernardino County Department of Behavioral Health provides:
• Free aids and services to people with disabilities to help them communicate better, such as:
• Qualified sign language interpreters
• Written information in other formats (large print, braille, audio or accessible electronic formats)
• Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact San Bernardino County Department of Behavioral Health 24 hours a day, 7 days a week by calling 1-888-743-1478. Or, if you cannot hear or speak well, please call TTY 711. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

LANGUAGE ASSISTANCE TAGLINES

English Tagline

ATTENTION: If you need help in your language call 1-888-743-1478 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-888-743-1478 (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-888-743-1478 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-888-743-1478 (TTY: 711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-888-743-1478 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-888-743-1478 (TTY: 711): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-888-743-1478 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-888-743-1478 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-888-743-1478 (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-888-743-1478 (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-888-743-1478 (TTY: 711) تماس بگیرید.
کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است.
با 1-888-743-1478 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-888-743-1478 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-888-743-1478 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nge Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-888-743-1478 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-888-743-1478 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は 1-888-743-1478 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-888-743-1478 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-888-743-1478 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-888-743-1478 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-888-743-1478 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-888-743-1478 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-888-743-1478 (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-888-743-1478 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-888-743-1478 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-888-743-1478 (TTY: 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-888-743-1478 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-888-743-1478 (линия TTY: 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-888-743-1478 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-888-743-1478 (TTY: 711). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-888-743-1478 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-888-743-1478 (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-743-1478 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-743-1478 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-888-743-1478 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-888-743-1478 (TTY: 711). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-888-743-1478 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-888-743-1478 (TTY: 711). Các dịch vụ này đều miễn phí.

Introduction: San Bernardino County, Department of Behavioral Health

The Department of Behavioral Health (DBH) is responsible for providing mental health and substance use disorder services to San Bernardino County residents who are experiencing major mental illness or substance use issues. DBH provides mental health and substance use disorder treatment to all age groups, with a primary emphasis placed on treating children/youth who may be seriously emotionally disturbed, adults who are experiencing a serious and persistent mental illness, and individuals who are experiencing substance use disorders. DBH also provides an array of prevention and early intervention services for both mental health and substance use.

Note: The term Client and Consumer are used interchangeably throughout the plan. Both terms represent individuals receiving services from the Department of Behavioral Health.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE
National Standards for Culturally and Linguistically Appropriate Services (CLAS Standard) 2, 3, 4, 9 & 15.

1-I: County Mental Health System Commitment to Cultural Competence.

The County shall include the following in the Cultural Competence Plan Requirements (CCPR): Policies, procedures, or practices that reflect steps taken to institutionalize the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health and Substance Use System.

1-I-A. The San Bernardino County Department of Behavioral Health (DBH) continues its strong commitment to cultural competency. Cultural Competence is embedded into our department's values, noting that "Clients and families are central to the purpose of our Vision and Mission. We embrace the following values: sensitivity to and respect for all clients, families, communities, cultures and languages, effective services in the least intrusive and/or restrictive environment, positive and supportive settings with state-of-the-art technologies, open and honest dialogue among all stakeholders, partnerships and collaborations that share leadership, decision-making, ownership and accountability…".

DBH continues to have in place policies and procedures that reflect steps taken to institutionalize the recognition and value of racial, ethnic, and cultural diversity within the county behavioral health system. These policies and procedures apply to all mental health and substance use disorder services rendered within the county behavioral health system. Below are our policies and procedures that are specific to meeting cultural competence that are part of the departments Standard Practice Manual (SPM):

- Behavioral Health Services for Clients/Family Members Who are Deaf of Hard of Hearing Policy: CUL1002
- Behavioral Health Services for Clients/Family Members Who are Deaf of Hard of Hearing Procedure: CUL1002-1
- Satisfying Clients' Language Needs Policy: CUL1004
- Consumer Focus Group Policy: CUL1005
- Consumer Focus Group Procedure: CUL1005-1
- Cultural Competency Policy: CUL1006
- Field Testing of Written Materials Policy: CUL1010
- Field Testing of Written Materials Procedure: CUL1010-1
- Providing Translation Services Procedure: CUL1011
- Providing Interpretation Services Procedure: CUL1012
- Providing Written Communications in Threshold/Primary Languages for Consumer/Family Members Policy: CUL1013
- Cultural Competency Training Policy: CUL1014
- Education and Training Policy: TRA8001

- Non-Discrimination-Section 1557 of the Affordable Care Act Policy: COM0953
- Affordable Care Act (ACA) 1557 Grievance Procedure: COM0953-1
- Written Informing Materials Policy: QM6012
- 24/7 Access Line Requirements Policy: QM6045
- 24/7 Access Line Requirements Procedure: QM6045-1
- Bilingual Certification Policy: HR4031

The Office of Equity and Inclusion (OEI) will continue to monitor and update the policies and procedures listed above to ensure they are up to date and in compliance with current state and federal policies and procedures as needed in FY 2025/2026. All policies listed above can be accessed on the DBH website located at https://wp.sbcounty.gov/dbh/forms/ under the Standard Practice Manual tab.

1-II: The County shall show Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System.

The Cultural Competency Plan Requirements (CCPR) shall be completed by the county Mental Health and Substance Use Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR. The county shall include the following in the CCPR:

1-II-A: A description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health and substance use services disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health and substance use planning processes and services development.

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to including diverse clients, family members, and stakeholders from throughout the county in the planning, implementation, and evaluation of programs and services. DBH encourages community engagement with the goal of empowering the community for the purpose of generating ideas, contributing to decision making and to engender a county/community partnership to improve behavioral health outcomes for diverse San Bernardino County residents.

DBH contracted providers participate in the department's efforts to promote the delivery of culturally and linguistically appropriate services. Language on cultural competence is included in all department contracts with providers to ensure contract services are provided in a culturally and linguistically appropriate manner (Attachment A1). DBH's Office of Equity and Inclusion (OEI) monitors providers on Cultural Competence requirements in collaboration with DBH's Offices of Compliance and Quality Management and provides technical assistance as needed to both mental health and substance use disorder providers.

DBH coordinates community outreach, engagement and collaboration with diverse racial, ethnic, cultural and linguistic communities through the Office of Equity and Inclusion (OEI), Mental Health Services Act (MHSA) Administration and Public Relations and Outreach Services (PROS). OEI is responsible for embedding the tenets of cultural and linguistic competency throughout all

levels of the organization. Services include multicultural education and training, coordination of language services (i.e., translation, as well as in-person, telephonic and video interpretation), development and implementation of culture-specific community-based programs (i.e., Community Health Workers/Promotores de Salud, Family Resource Centers, etc.), and community engagement in program planning and service delivery. OEI is managed by the Equity and Cultural Competency Officer (ECCO).

Additionally, OEI staff attend several community and faith-based meetings to listen and promote DBH services, further discussed in 1-II-B. OEI manages and supports the department's Cultural Competency Advisory Committee (CCAC), further discussed in Criterion 4. MHSA ensures there is a robust community planning process in place to encourage community contribution to improve behavioral health outcomes. PROS promotes DBH's services and DBH's Mental Health Services Act (MHSA) investment.

DBH's MHSA Community Program Planning (CPP) protocol includes a participatory framework of regular, ongoing meetings with diverse stakeholders to discuss topics related to behavioral health policy, pending legislation, program planning, implementation and evaluation, and financial resources associated with behavioral health programs. DBH's CPP program received a National Association of Counties (NACo) Achievement Award in June of 2022.

This practice has allowed DBH to:

- Be responsive to changes and concerns in the public behavioral health environment.
- Establish and maintain a two-way communication pathway for community-identified areas of improvement, which are introduced into DBH's larger process improvement efforts and report results back to the broader community.
- Encourage community involvement in DBH's planning beyond the typical "advisory" role.
- Educate clients and stakeholders about behavioral health resources and topics and the public behavioral health system.

DBH ensures diverse attendance by maintaining a published schedule of meetings and advertising these meetings using social media, press releases, other county departments, and an expansive network of known cultural brokers, community partners and contracted vendors.

To ensure participation from diverse stakeholders, meetings include interpreter services or, as the occasion dictates, meetings held in languages other than English. Meeting locations are coordinated in every region of San Bernardino County, and web-conference/virtual style meetings are available for remote communities or for individuals who are unable to attend an in-person session or prefer the web format. Meetings are documented through agendas and minutes. Stakeholder attendance is recorded through meeting sign-in sheets, virtual login tracking and chat features (Microsoft Teams, Zoom), and feedback forms. Feedback forms and live virtual polling capture the attendance of underserved, unserved, and inappropriately served populations.

Due to the COVID-19 pandemic, meetings after March 2020 were held only on virtual platforms in compliance with state guidelines to limit/end in person gatherings. Meetings in FY 2024/2025 were delivered virtually, in person and hybrid formats. Stakeholders have expressed that virtual platforms are more accessible to them and would like to continue virtual meetings beyond the COVID-19 pandemic, when appropriate.

The following are regularly scheduled DBH meetings:

- Behavioral Health Commission (BHC): Twelve annual-monthly meetings
- District Advisory Committee meetings: Five monthly meetings; sixty annual meetings
- Community Policy Advisory Committee (CPAC): Twelve annual meetings-monthly meetings
- Cultural Competency Advisory Committee (CCAC): Twelve annual meetings-monthly meetings
- Association of Community Based Organizations (ACBO): Twelve annual meetings-monthly meetings
- Substance Abuse Provider Network (SAPN): Four annual quarterly meetings
- Prevention and Early Intervention Provider Network Meeting (PEIPNM): Four annual quarterly meetings

OEI manages and supports the DBH Cultural Competency Advisory Committee (CCAC) and its fourteen (14) subcommittees (Attachment A2). CCAC is a committee made up of community-based providers, organizations, partner agencies, consumers, family members, faith-based organizations/individuals, representatives from various DBH departments, primary care providers and other interested parties. CCAC has established direct channels of communication with OEI staff and the ECCO. CCAC interacts closely and advises the ECCO on pertinent information and research data regarding the needs of communities of color and culture in the county. Likewise, information also flows from the ECCO and OEI to the CCAC and the diverse communities the membership represents. The CCAC and subcommittees meet monthly.

Subcommittees include:

1. African American Awareness Subcommittee
2. Asian/Pacific Islander Awareness Subcommittee
3. Consumer and Family Member Awareness Subcommittee
4. Mental Health and Substance Use Awareness Subcommittee
5. Disabilities Awareness Subcommittee
6. Latino Awareness Subcommittee
7. Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Awareness Subcommittee
8. Native American Awareness Subcommittee
9. Older Adult Awareness Subcommittee
10. Spirituality Awareness Subcommittee
11. Suicide Prevention Awareness Subcommittee
12. Transitional Aged Youth Awareness Subcommittee
13. Veterans Awareness Subcommittee
14. Women's Awareness Subcommittee

OEI in collaboration with the CCAC and community partners hosts community events focused on outreach to the community, reducing stigma around mental health and substance use, increasing access to behavioral health services, and introducing behavioral health services to underserved communities. In FY 2024/2025, the CCAC, in partnership with DBH planned and delivered an in person summit (Attachment A3). Attendance included 92 consumers, community partners, DBH staff and stakeholders .

CCAC Summit 2024
Date: October 29, 2024
Location:
Immanuel Praise Fellowship
9592 7th Street, Rancho Cucamonga, CA
Unity in Resiliency

In FY 2025/2026 the CCAC planned their fifth summit. This time an in-person event will take place on October 30, 2025. (Attachment A4).

During FY 2024/2025, the ECCO continued to oversee the Office of Equity and Inclusion (OEI)**.** OEI's staff consists of two Peer and Family Advocates (PFA). PFAs enhance family participation in the treatment process and assist clients in learning how to advocate and make choices to determine their path of recovery. PFAs assist and support clients and their families in navigating the DBH system of care and linking them to appropriate services for treatment. OEI also develops and delivers trainings to behavioral health staff and community partners on client/consumer culture to increase their awareness. OEI's PFAs serve as members of the Cultural Competency Advisory Committee (CCAC), discussed later in Criterion 4, and facilitate the Consumer and Family Members Awareness Subcommittee which solicits input from consumers and their family members on our department's program planning and service delivery. OEI staff also support and facilitate the CCAC Disabilities, Native American, Older Adults and Women's Awareness Subcommittees. OEI PFAs serve as members of the departments Quality Management Action Committee (QMAC) and its workgroups provide insight on the consumer and family experience in navigating the system of care. Additionally, OEI staff attend several community and faith-based meetings to listen and promote DBH services, further discussed in 1-II-B.

The Public Relations and Outreach Services (PROS) division leads countywide outreach initiatives to raise awareness about behavioral health services and connect communities with available resources. Outreach for general behavioral health services is conducted in underserved communities through K-12 school programs, health and resource fairs, recovery events, homeless outreach, veterans' events, and other community gatherings. In FY 2024/2025, PROS participated in 378 total outreach events.

The Outreach Taskforce, a group of trained outreach professionals and subject matter experts from various departments, continued to grow and lead outreach efforts across the San Bernardino County region. Taskforce members received regular communication and cultural competency training to enhance their ability to serve the community. In FY 2024/2025, the Outreach Taskforce consisted of 53 members. Outreach to county-identified racial and ethnic target populations was carried out through direct engagement, collaboration with the department's cultural subcommittees, and partnerships with external organizations.

In FY 2024/2025, DBH participated in events focused on African American, Latino/Hispanic, and LGBTQ communities, including major events such as San Bernardino Pride, the 2nd Annual African American Mental Health Awareness Conference: Just Breathe, the Mexican Consulate Annual Resource Fair, and the Morongo Tribal TANF Program Resource Fair. Additionally, PROS participated in various community-based organizational meetings that helped identify unserved and underserved populations and their needs, allowing the Department of Behavioral Health (DBH) to address service gaps and disparities.

During Mental Health Awareness Month in May, DBH increased its outreach efforts to highlight mental health awareness. In FY 2024/2025, DBH participated in 63 outreach events across the entire San Bernardino County service area during this month alone. These events aimed to reduce the stigma surrounding mental health and substance use services, increase access to behavioral health resources, and introduce these services to underserved communities. One event held in FY 2024/2025 was the "Summer Wellness Extravaganza" on Saturday, July 20th, 2024. The event centered on fostering intergenerational connections and promoting both emotional and physical well-being across the community. The event was delivered through a collaborative partnership with the Department of Aging and Adult Services, Big Brothers Big Sisters, and California State University, San Bernardino.

Over the past year, the Department of Behavioral Health's social media presence has demonstrated strong growth and engagement across all platforms. Collectively, DBH's pages reached more than 7.5 million people, generating over 5.9 million impressions and achieving an average engagement rate of 7.39%, a strong indicator of audience connection and content relevance.

DBH's total following grew to 11,649 followers, with 1,373 new followers gained during the reporting period. Posts received 6,727 reactions and likes, 1,443 shares, and 238 comments, showing consistent interaction from our community. Additionally, posts with external links generated 7,970 clicks, further demonstrating audience interest in learning more about DBH programs and resources.

This year's analytics highlight the department's continued progress in expanding digital outreach and fostering meaningful engagement around behavioral health awareness, prevention, and community connection.

DBH recognizes and continuously aims to increase racial, ethnic, cultural and linguistic diversity within our system of care. This is accomplished through many strategies, including:

- Department Diversity Committee (DDC) – The mission of the DDC is to promote diversity and inclusion through the department's workforce. The DDC is made up of DBH staff from different workforce units and staff that represent the four regions of the county. The DDC is managed by the Equity and Cultural Competency Officer (ECCO) and supported by one staff from the Office of Equity and Inclusion (OEI). OEI staff provided administrative support to the DDC ensuring efforts are documented and task are tracked.
- Bilingual Paid Staff – DBH offers a pay differential for staff who are tested and certified as bilingual in one of two categories: Verbal and Written/Technical. A list of bilingual paid staff is generated every six months and distributed to programs to encourage the use of our own staff for translations and interpretations before using external contracted language service providers. The use of bilingual staff is discussed further in Criterion 7.
- Human Resources (HR) – The Human Resource Department continues to find ways to tailor recruitment efforts to applicants who are representative of the racial/ethnic and linguistic population DBH serves. Such as highlighting the departments' bilingual language skills need on all job announcements under desired qualifications, hoping to capture candidates with various backgrounds and experiences (Attachment A5). DBH has demonstrated success in recruitment efforts through the racial/ethnic diversity of our staff which in FY 2024/2025 was 45.1% Latino, 20.1% Caucasian, 16.7% African American, 7.2% Asian, 0.7% American Indian/Alaska Native, 0.7% Native Hawaiian/Pacific Islander, 6.4% Two or More Races, and 3.2% not specified. We continue to strive towards

building and maintaining diversity within our department at all levels, further discussed in Criterion 6.

1-II-B: A narrative description addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the behavioral health system's planning process for services.

The Office of Equity and Inclusion (OEI) continues to work with both formal and informal diverse community groups to solicit input and feedback on our service delivery and engage them in our planning process for services. This is done through the Cultural Competency Advisory Committee (CCAC) and 14 subcommittees, but also through ongoing engagement by staff in attending various community, faith based and department workgroup meetings to inform on the planning, development and enhancement of services.

DBH works with the Mexican Consulate to address the behavioral health needs of Latino communities, including new arrivals and their families. In FY 2024/2025, DBH continued to host a monthly resource table at the Mexican Consulate. The table is staffed by bilingual Spanish speaking staff and provides behavioral health information and resources as well as overdose prevention training.

OEI works closely with the LGBTQ community through the LGBTQ Awareness Subcommittee of the CCAC, comprised of several community organizations and stakeholders, to update the LGBTQ Resource Guide and make it available, upon request. This guide was created out of community feedback regarding the concern of lack of appropriate behavioral health services available to the LGBTQ population. By maintaining the guide and relationships with LGBTQ serving entities, DBH has ensured a voice for this community in the planning and evaluation of services. OEI sponsored Family Assistance Program's San Bernardino 2025 Pride Event which provided a safe and inclusive environment for LGBTQ individuals and allies in East Valley to connect, celebrate diversity and promote understanding and acceptance.

The West Side Action Group (WAG) meets every Monday virtually to discuss its mission of influencing the local political and economic agenda and raise money to train and elect African Americans from the local community to public office. OEI staff continue to be invited to regularly attend WAG meetings and provide department updates. WAG is an active partner in the planning of DBH services.

OEI staff attend and support San Bernardino County Gangs and Drugs Taskforce meetings once a month to seek opportunities of collaboration, identifying potential speakers/presenters for DBH and contract staff and to bring back information on county efforts to combat gangs and drugs in the county. Staff network with other meeting attendees and foster positive community engagement.

OEI staff with lived experience continues to participate in Crisis Intervention Trainings (CIT) for law enforcement and first responders to train them on working with families and individuals in accessing appropriate behavioral health services and resources during a mental health crisis. All OEI interns also participate in CIT as part of their training.

OEI staff attend the monthly Faith Based Network Luncheon. The luncheon provides and opportunity for faith-based non-profits and governmental organizations to come together to share resources and information about events.

OEI Staff attend the monthly Inland Empire Health Plan Community Partner Network to gather information and resources and exchange ideas with the aim of fostering higher levels of cooperation, collaboration, and community support.

OEI staff attend the monthly Inland Empire Disabilities Collaborative (IEDC) meeting. IEDC is a non-profit public benefit and governmental organization to promote advocacy with and for people with disabilities. IEDC partners to host events that benefit the community and come together to share resources.

OEI staff attend the quarterly Native American Coalition meeting, hosted by the Inland Regional Center. This coalition brings together community members, advocates, and service providers to address the unique needs of Native American individuals, fostering awareness, improving access to resources, and supporting cultural competence within service delivery.

The ECCO and OEI attend monthly Behavioral Health Commission (BHC) meetings to gather information and opportunities for CCAC members to be involved in behavioral health service planning. BHC advises the San Bernardino County Board of Supervisors and Behavioral Health Director on aspects of local behavioral health programs. The BHC is divided into five areas consistent with the five supervisory districts of the county. Each area has a sub-committee, known as a District Advisory Committee (DAC), which meets monthly to gather and provide the Department of Behavioral Health, through the BHC, feedback on the needs of their region. DAC meetings are held monthly and are open to the public. OEI staff also attend BHC District Advisory Meetings when their schedules allow to promote DBH and CCAC meetings and events.

DBH's Quality Management Program includes a Consumer/Family Member Evaluation and Contributions Workgroup for consumers, family and community members who participate in mental health and/or substance services. Participants set objectives, goals, activities and participate in the department's quality assurance efforts on a bi-monthly basis. This workgroup continues to be included in the department's Quality Improvement Performance Plan (QIPP) in FY 2024/2025 Quality Management – DBH Internet Website (sbcounty.gov).

The ECCO and OEI staff regularly meet with community leaders, community-based organizations, clients and family members, and behavioral health commission members to address concerns in the community, plan services and programs that are responsive to the needs of the community, collaborate on local events, and remain responsive to our diverse communities.

1-II-C: A narrative discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

DBH recognizes the importance of building the capacity of our community partners in order to effectively deliver quality essential services. One of the ways that we increase the quality of services provided by our partner agencies is through cultural competency trainings. Cultural competency trainings enhance the skills of providers and their ability to provide culturally and linguistically appropriate services to our diverse communities. The ECCO and OEI staff facilitate and provide training on cultural competence and diversity to external partner agencies, community

organizations and other county departments. OEI also reviews trainings provided to determine if they meet the culturally competency training standards for continuing education units, set by the department. OEI also provides training and technical assistance to contracted providers in adopting and reporting on their implementation of the department's cultural competency plan and the National Standards for Culturally and Linguistically Appropriate Services (CLAS). In FY 2024/2025, OEI staff provided 32 trainings on cultural competence and diversity to department staff, contract providers and community stakeholders including, but not limited to:

- Spanish Clinical Skills for Direct Service Providers
- Introduction to Racial Based Trauma
- Implicit Bias
- Recovery, Resilience and Wellness
- Consumer/Peer and Family Movement

Training efforts are further discussed in Criterion 5.

Community Education Program (CEP) continues to facilitate behavioral health educational opportunities throughout the county with the community bring the primary target audience. This program aims on collaborating with community-based organizations, faith-based groups, educational organizations, and other private and public agencies to bring more awareness on behavioral health, wellness, resources, and linkage to services. CEP offers the following certified curriculum: Adult Mental Health First Aid, Youth Mental Health First Aid, safeTALK, Applied Suicide Intervention Skills Training (ASIST), and Listen Empathize Agree and Partner (LEAP). CEP also offers customized training opportunities when requested.

The department continues to provide Listen Empathize Agree and Partner (LEAP) training to community and faith-based partners. LEAP training educates the public about the unmet needs of persons with mental illness and anosognosia. The training provides family members, behavioral health providers and criminal justice professionals a skillset to create a therapeutic alliance with persons who have severe mental illness, which can lead to receiving treatment and services. Utilizing LEAP within the Recovery Based Engagement Support Team (RBEST) program, the Connecting Families group was designed as part of the LEAP continuum of care to support families of individual's living with severe and persistent mental health illness. In FY 2024/2025 a total of 285 community members completed LEAP training with CEP.

DBH continues to regularly engage in skill-building with our law enforcement partners through Crisis Intervention Trainings (CIT) teaching first responders how to effectively de-escalate situations, identify mental health issues and how it may impact their encounter with community members, and recognizing the cultural consideration that should be taken in working with our diverse communities. The Peer and Family Advocates (PFAs) of OEI participate regularly in the 40-hour CIT Training. PFAs are essential in lending lived behavioral health experience to the training of first responders. OEI staff participate in the 40-hour CIT training role-play scenarios as role-players and evaluators giving first responders the ability to put into action the skills taught in the training. As mental health evaluators in the role-plays, OEI staff provide constructive feedback to the first responder on behavioral health crisis considerations and available resources that may assist the first responders and community member in the field. This collaborative effort aids in San Bernardino's population with behavioral health needs obtain the appropriate level of care needed in the least restrictive manner when appropriate.

The Prevention and Early Intervention Provider Network meeting strives to ensure that providers stay informed about legislative changes while providing technical assistance and guidance to enhance their internal business processes. Furthermore, DBH staff provide support for decision-making in programming and facilitate avenues for growth.

The Wellness Conference (WC) is an engaging multi-day event designed to empower educational partners such as mental health professionals, administrators, educators, school counselors, school safety staff, healthcare providers, and the community to address the needs of the whole child. DBH provides financial and staff support for this annual conference.

In addition, skills development and strengthening is enhanced using outreach engagement activities such as community fairs, community events, and information sessions. Participation in specified activities creates a conduit for information to be shared between community organizations and the department. Information is gathered and presented to the DBH executive management team on the service delivery needs of community organizations.

1-II-D: Share lessons learned on efforts made on the items A, B, and C above.

DBH's Crisis Intervention Trainings (CIT) continue to work on enhancing the cultural competency lesson plans of their CIT courses to make it more relevant to the first responders and the communities they serve. One of the current efforts is to provide first responders and community partners with a teaching block of cultural considerations and updated trends of the communities they serve. The CIT program along with the OEI will continue to work together to identify and develop a cultural competency educational block that can be implemented as an adult learning activity for the 40-hour CIT course. The learning activity will continue to enhance the learning experience and information retention for our first responders and community partners.

To better align department programs, the Community Education Program (CEP) successfully transitioned the safeTALK and ASIST curriculums to the Office of Suicide Prevention (OSP), which is part of the Public Relations and Outreach Services **(**PROS) office. Effective in Fiscal Year 2025-26, OSP and PROS will manage all coordination efforts for these two (2) curriculums. CEP will continue to work in partnership with OSP and PROS to help educate the community on these important topics.

1-II-E: Identify County technical assistance needs.

There are no areas requiring technical assistance at this time.

1-III: Each County has a Designated Cultural Competence/Ethnic Services Manager (CC/ESM) Person Responsible for Cultural Competence. The CC/ESM will report to, and/or have direct access to, the Mental Health Director regarding issues impacting mental health and substance use issues related to the racial/ethnic, cultural, and linguistic populations within the county.

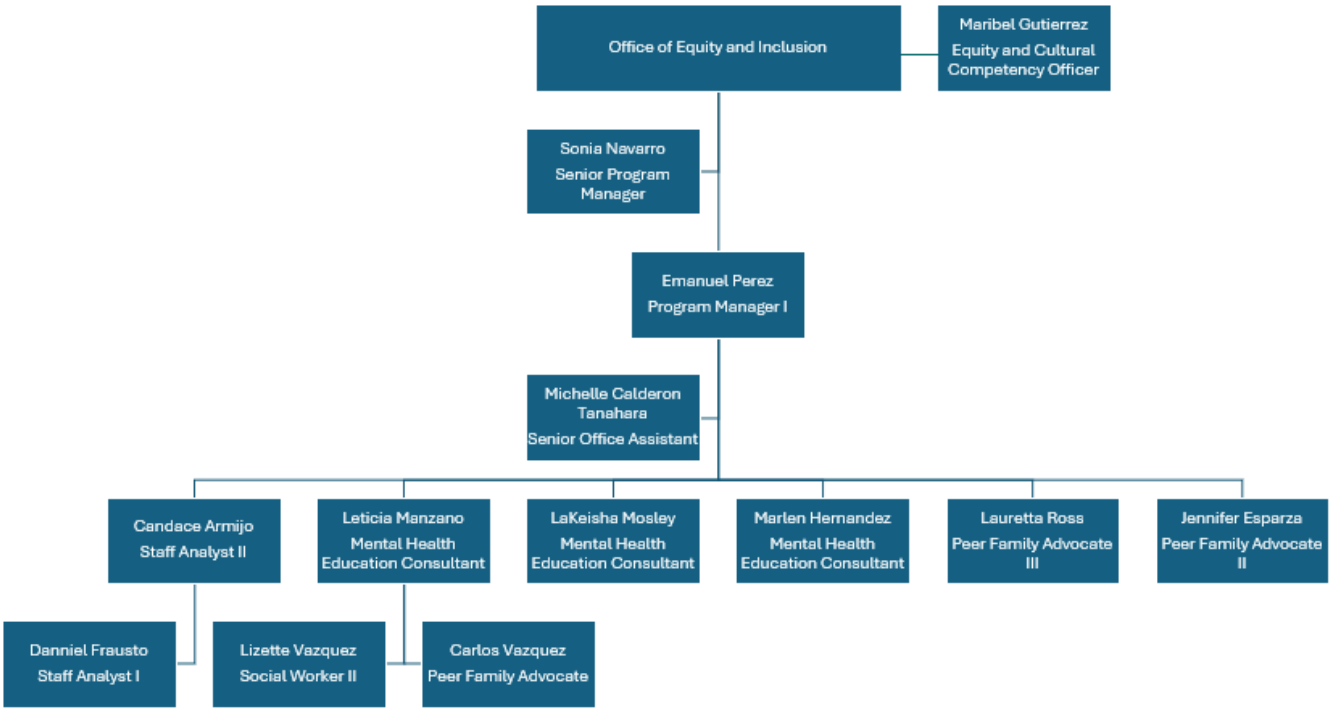
1-III-A: Evidence that the County Behavioral Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate

mental health and substance use services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

The Department of Behavioral Health (DBH) has a designated Equity and Cultural Competency Officer (ECCO) who is responsible for embedding the tenets of cultural competence throughout the system of care and promotes the development of culturally appropriate behavioral health services to meet the diverse needs of our racial, ethnic, cultural and linguistic populations. The Deputy Director of Community Engagement and Equity Services (CEES) serves as the ECCO and reports to the Director of the Department. A Senior Program Manager reports to the Deputy Director of CEES and directly manages the day to day of the Office of Equity and Inclusion (OEI) and Mental Health Services Act (MHSA) Administration.

All programs under CEES Division actively engage with diverse stakeholders to meet the cultural competency plan and MHSA community program planning requirements. Staffing includes twelve (12) positions indicated in the organizational chart on page 12. The current Equity and Cultural Competency Officer (ECCO) has continued in their role since July 2019.

Chart 1: OEI Organizational Chart



1-III-B: Written description of the cultural competence responsibilities of the designated CC/ESM.

The following is the description of responsibilities of the Equity and Cultural Competency Officer (ECCO) as indicated in the job description.

Definition

Under general direction, plan, implement, monitor and evaluate Behavioral Health's cultural and linguistic healthcare and outreach services and programs; coordinate and promote quality and equitable care to racial and ethnic populations; develop, coordinate, and facilitate the implementation of the Cultural Competency Plan including a Training and Education Program; performs related duties as required.

Distinguishing Characteristics

This is a single position classification responsible for administering, implementing, maintaining, and evaluating all direct services for the Cultural Competency Program and supervising and training program staff. This position reports to the Director of Behavioral Health.

Examples of Duties:

Duties may include, but are not limited to, the following:

1. Plan, assign, review, and evaluate the work of assigned staff. Prepare and sign performance evaluations; hire staff and recommend and implement disciplinary actions.
2. Plan, develop, implement and monitor a cultural and linguistic healthcare and outreach program; develop and implement translation and interpretation services.
3. Develop and implement strategies to achieve a culturally competent system of care for the implementation of the Mental Health Services Act (MHSA).
4. Develop and manage the implementation of the department's Cultural Competency Plan.
5. Participate in the monitoring of county and service contractors to ensure service delivery complies with local and State mandates as they affect underserved populations.
6. Identify local and regional cultural behavioral health needs of ethnically and culturally diverse populations as they impact county systems of care; make recommendations to department management.
7. Develop budgets for MHSA outreach activities such as training, staffing and supplies.
8. Maintain an ongoing relationship with community organizations, planning agencies, and the community at large.
9. Provide vacation and temporary relief as required.

1-IV: Identify Budget Resources Targeted for Culturally Competent Activities.

1-IV-A: Evidence of a budget dedicated to cultural competence activities.

In FY 2024/25, the Office of Equity and Inclusion (OEI) had an allocated budget of $1,301,676 dedicated to cultural competence activities.

In 2024/25 Public Relations and Outreach Services (PROS) had an allocated budget of $1,893,060.32 to promote DBH programs and services.

1-IV-B: A discussion of funding allocations included in the identified budget above in Section A, also including, but not limited to, the following:

1. **Interpreter and translation services;**
2. **Reduction of racial, ethnic, cultural, and linguistic mental health disparities;**
3. **Outreach to racial and ethnic county-identified target populations;**
4. **Culturally appropriate mental health services;**
5. **If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.**

The funding allocations identified in the budget above include salary and benefits of all OEI staff and programmatic and operational costs for the office. The staffing of OEI and staff responsibilities are as follows:

- Equity and Cultural Competency Officer (ECCO) - Plans, implements, monitors and evaluates Behavioral Health's cultural and linguistically appropriate healthcare and outreach services and programs; coordinates and promotes quality and equitable care to diverse racial, ethnic, cultural, and linguistic populations; develops, coordinates, and facilitates the implementation of the Cultural Competency Plan including a Training and Education Program.
- Three (3) Mental Health Education Consultants (MHEC) – Facilitate culturally-relevant trainings and staff development and conduct community outreach and behavioral health education to diverse communities. Mental Health Education Consultants also support the 14 subcommittees of the Cultural Competency Advisory Committee and serve as liaisons/cultural brokers between the department and the diverse communities we serve.
- Staff Analyst II – Provides direct monitoring of language services contracts. Reviews and updates Cultural Competency program policies and procedures. Analyzes data. Conducts research. Prepares program reports and documentation for department state reviews and audits. Conducts program monitoring and assists in program development. Facilitates meetings. Participates in quality improvement project development and implementation. Assist with developing evaluation tools. Supervises staff.
- Staff Analyst I: Provides direct monitoring of language services contracts. Analyzes data. Prepares program reports and documentation for department state reviews and audits. Conducts program monitoring and assists in program development.
- Social Worker II – Conducts community outreach and education and serves as a liaison/cultural broker between the department and the diverse communities we serve. Provides administrative support to the 14 subcommittees of the Cultural Competency Advisory Committee (CCAC).
- Senior Office Assistant – Provides administrative support, meeting coordination, scheduling, and travel arrangements for OEI staff.
- Three (3) Peer and Family Advocates – Assist individuals and families in navigating the behavioral health system of care. Provide culturally specific, client-focused trainings to department staff and the community. Serve as liaisons/cultural brokers between the department and the diverse communities we serve. One position vacant in June 2025.
- Program Manager I: Supervises the Office of Equity and Inclusion, provides direct monitoring of Behavioral Health's cultural and linguistically appropriate healthcare and outreach services and programs; coordinates and promotes quality and equitable care to diverse racial, ethnic, cultural, and linguistic populations.

- Senior Program Manager: Manages the Office of Equity and Inclusion and Mental Health Services Act (MHSA) Administration to ensure cultural and linguistic requirements are aligned with Behavioral Health, MHSA community program planning requirements and DHCS requirements.

Interpreter and Translation Services:

A significant budget is allocated for Language and Interpretation Services in DBH's department budget. OEI staff are responsible for fielding questions, requests and complaints for all translations and interpretations internally and externally, i.e., from DBH staff and contract providers. OEI staff also monitor all Language Services Contracts, with the goal of ensuring linguistically appropriate services are available for the Limited English Proficiency (LEP) population, hard of hearing, and deaf. For FY 2024/2025, DBH expended $1,143,976.50 for language services.

Reduction of racial, ethnic, cultural, and linguistic mental health disparities:

To reduce disparities within our underserved cultural populations, DBH's Prevention and Early Intervention (PEI) program continues to fund the following programs:

- The Resilience Promotion in African American Children (RPIAAC) a program that provides mental health prevention and early intervention services designed to address the needs of African American children/youth and their families. Funded in the amount of $5,100,000 for the period of July 1, 2023, through June 30, 2026.

- The Older Adult Community Services (OACS) program. OACS is categorized as a Prevention State program that also provides early intervention services. OACS program services target older adults (ages 60+) that are at risk for developing mental health concerns. The program was designed to address key indicators like depression, isolation, chronic physical health conditions, and lack of family support system that may lead to mental health concerns. The OACS program utilizes tools to assess for risk of suicide, health concerns, close supports and depression during their program intake to link participants to the appropriate services. Funded for the amount of $3,150,000 for the period of January 1, 2021, through June 30, 2026.

- The Community Health Workers/Promotores de Salud Program is a program that deploys trained individuals who have received behavioral health services into targeted communities. The purpose of the program is to provide outreach to increase recognition of early signs of mental illness in the African American/Black, Asian/Pacific Islander, Latinos, LGBTQ and Native American communities. Funded for the amount of $3,793,287 for the period of July 1, 2022, through June 30, 2026.

- The Native American Resource Center (NARC) a program that focuses on reducing stigma and discrimination associated with mental illness, increasing early access and linkage to medically necessary care and treatment, and improving timely access to services for the underserved Native American population. Funded with the amount of $2,500,000 for the period of July 1, 2020, through June 30, 2026.

- The Military Services and Family Support Program (MSFS) a prevention and early intervention program that provides mental health services to military veterans, active duty and retired military personnel, reservists, and members of the National Guard who served on or after September 11, 2001, and their families, throughout San Bernardino County. Services address the negative effects of traumatic events and other unique challenges of military life; services are provided in-home and/or in the community. Funded in the amount of $3,625,000 for the period of July 1, 2022, through June 30, 2026.

- The Coalition Against Sexual Exploitation (CASE) of San Bernardino County is a collaboration of public and private organizations with the common goal of pooling resources to combat the commercial sexual exploitation of children. CASE partner organizations combine resources to educate the community and protect, intervene, and treat children and youth who are victims of commercial sexual exploitation. CASE provides direct services to children who have been identified as commercially sexually exploited, or CSEC. The multidisciplinary team includes social workers from Children and Family Services, Public Defenders Office, and Behavioral Health; attorneys from the District Attorney's office and Public Defenders office; a probation officer, a public health nurse, an Alcohol and Drug Counselor, and advocates from Court Appointed Special Advocate (CASA), Open Door; and an educational consultant from San Bernardino County Superintendent of Schools provides direct services. In FY 2024/2025 CASE was funded in the amount of $391,482.

- The Substance Use Prevention and Pathways to Outreach and Treatment (SUPPOrT) , is a program categorized as an Outreach for Increasing the Recognition of Early Signs of Mental Illness. It encompasses a multidisciplinary mix of partners working across sectors that include county agencies, community agencies and institutions, professional partners, and residents working together to educate one another and support and develop strategies to combat the opioid crisis. The goal is to continue to work collaboratively across partnerships to reduce opioid use and opioid-related deaths in San Bernardino County. In FY 2024/2025, SUPPOrT was funded in the amount of $417,500.

Each of the PEI programs mentioned above have their own budget allocation; these allocations are not embedded within the OEI budget.

Additionally, OEI staff are committed to supporting the Cultural Competency Advisory Committee (CCAC) and fourteen (14) subcommittees. The subcommittees advocate for the development, implementation and evaluation of high quality, culturally/linguistically attuned, behavioral health services capable of meeting the diverse needs of all cultural groups in San Bernardino County. Some of the events hosted or partnered by the CCAC and subcommittees in FY 2024/2025 include:

- InSite - Just Breathe Conference
- Vibe Wellness Festival 2024
- NAMI Walks
- 45th Annual Martin Luther King Jr. Breakfast
- San Bernardino Pride 3rd Annual

The CCAC has direct channels of communication with OEI staff, and the ECCO. The CCAC interacts closely with and advises the ECCO to share pertinent information and research data

regarding the special needs of the target populations in the community. Likewise, information will flow from the ECCO to the CCAC to ensure their active participation in the delivery of services, policies and procedures to the diverse communities of San Bernardino County.

Outreach to racial and ethnic county-identified target populations:

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to outreach to diverse clients, family members, and stakeholders from throughout the county. DBH encourages community engagement with the goal of empowering the community for the purpose of generating ideas, contributing to decision making and to engender a county/community partnership to improve behavioral health outcomes for diverse San Bernardino County residents.

DBH hosts community events focused on outreach to the community, reducing stigma around mental health and substance use services, increasing access to behavioral health services, and introducing behavioral health services to underserved communities. Some of the events conducted in FY 2024/2025 include:

- October 29, 2024: The Cultural Competency Advisory Committee (CCAC) held an in-person Summit that focused on healing through hope and resiliency.
- October 8, 2024: The Spirituality Awareness Subcommittee hosted Embracing Hope: Healing Minds and Restoring Lives, an in-person event with guided meditation, panel discussion, and a cultural healing activity in celebration of National Day of Prayer .
- May 20, 2025: The Native American Awareness Subcommittee hosted a virtual event to honor and discuss Missing and Murdered Indigenous Relatives in honor of Missing and Murdered Indigenous People awareness month.

The Office of Public Relations (PROS) partners with cultural, ethnic, and faith-based groups, schools, nonprofits, and other community organizations to offer presentations on topics such as mental health, substance use disorders, overdose prevention, and more. Outreach to county-identified racial and ethnic target populations was carried out through events such as San Bernardino Pride, the 2nd Annual Black Mental Health Awareness Conference: Just Breathe, the Mexican Consulate Annual Resource Fair, the Morongo Tribal TANF Program Resource Fair, the Chemehuevi Tribal Annual Health Fair, Latino Education and Advocacy Day, Leap into Greatness: A Celebration of Black Culture, the Filipino Baryo Fiesta, and more.

The Substance Use Prevention and Pathways to Outreach and Treatment (SUPPOrT), serves all populations in the San Bernardino County region, including the youth with a strong focus on reaching out/serving our unrepresented/underserved groups, such as African American, Latino, and LGBTQ. In addition, the program is currently in the process of reaching out to Native American Tribal organizations.

Culturally appropriate mental health services:

All DBH services are reviewed to be culturally appropriate. Many of the department's programs have components that appropriately address mental health and substance use disparities, provide outreach to racial and ethnic target populations, and provide culturally appropriate mental health services. Some of the most specific examples of programs that achieve these goals are listed below:

- Resilience Promotion in African American Children (RPIAAC)

- Community Health Workers/Promotores de Salud Programs
- Native American Resource Center (NARC)
- Military Services and Family Support Program (MSFS)
- Substance Use Prevention and Pathways to Outreach and Treatment (SUPPOrT) Behavioral Health Ministries Pilot Project (BHMPP)
- PEI statewide Suicide Prevention project administered by California Mental Health Services Authority (CalMHSA).

Descriptions of each of these and many other culturally specific programs are provided in Criterion 3.

Financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers:

A bilingual pay differential is paid to certified (tested) bilingual employees (Verbal: $50 per pay period, Technical: $60 per pay period and $45 for Management and Exempt bilingual employees). In FY 2024/2025, $353,124.63 was paid in bilingual pay differential to DBH employees.

CRITERION 2: UPDATED ASSESSMENT OF SERVICES NEEDS

CLAS Standard: 2

2-I: General Population.

2-I-A: Summarize the county's general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data.

Table 1: San Bernardino County's General Population Summary 2025

Demographic Characteristics of San Bernardino County

Total Population	2,195,611
Gender	%
Female	50%
Male	50%
Other/Not listed	0%
Age	%
0-15 years	22%
16 - 25 years	14.5%
26-59 years	45%
60 years and up	18.5%
Ethnicity	%
African American	7.5%
Asian/Pacific Islander	8.6%
Caucasian	23.9%
Latino	55.9%
Native American	0.3%
Other/Unknown	3.8%

Data Source: California Department of Finance Demographic Research Unit

2-II: Medi-Cal Population Service Needs

2-II-A: Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender.

In FY 2024/2025, San Bernardino County had 1,031,841 Medi-Cal eligible beneficiaries (See Table 2). An increase of 105,877 from the previous year.

Race/Ethnicity
Beneficiaries by race/ethnicity was as follows: 9.7% were African American, 5.3% were Asian/Pacific Islander, 14.8% were Caucasian, 57.8% were Latino, 0.2% were Native American, and 12.2% identified as Other.

Language
Beneficiaries' language preference was as follows: English 68.4%, Spanish 19.2%, Mandarin 0.8%, Vietnamese 0.3% and 11.2% identified as Other.

Age
Beneficiaries by age group was as follows: 27.7% were children (0-15 years), 17.1% were TAY (16-25 years), 40.7% were adults (26-59 years), and 14.6% were older adults (60 years and up).

Gender
Beneficiaries by gender were as follows: 53.8% were female and 46.2% were male.

The Medi-Cal population is geographically distributed throughout the county: 30% reside in the Desert/Mountain region, 24.3% reside in the East Valley region, 21% reside in the Central Valley, 21.2% reside in the West Valley, and 3.5% reside out of county.

Medi-Cal Mental Health clients

The Department of Behavioral Health (DBH) served 30,885 unduplicated Medi-Cal Mental Health clients in FY 2024/2025 (Table 2). A decline of 71 from the previous fiscal year.

Race/Ethnicity

Clients' race/ethnicity was as follows: 15.4% were African American, 2.1% were Asian/Pacific Islander, 20.3% were Caucasian, 45.7% were Latino, 0.4% were Native American, and 16.1% identified as Other.

Language

Clients' language preference was as follows: English 87.7%, Spanish 6.5%, Vietnamese 0.2%, and 5.5% identified as Other.

Age

Clients by age group was as follows: 33.3% were children (0-15 years), 19.4% were TAY (16-25 years), 39.2% were adults (26-59 years), and 8.1% were older adults (60 years and up).

Gender

Clients by gender was as follows: 48.6% were female, 50.8% were male and 0.6% identified as unknown.

Table 2: Mental Health Program Medi-Cal Indicators for Fiscal Year 2024/2025

	Medi-Cal Beneficiaries		Medi-Cal Mental Health Clients		Medi-Cal Penetration Rate
	1,031,841	**100.0%**	**30,885**	**100.0%**	**3.0%**
Gender		%		%	%
Female	555,070	53.8%	15,003	48.6%	2.7%
Male	476,771	46.2%	15,702	50.8%	3.3%
Other/Not listed	0	0.0%	180	0.6%	NA
Age		%		%	%
Children (0-15 y)	285,372	27.7%	10,285	33.3%	3.6%
TAY (16-25 y)	176,229	17.1%	5,980	19.4%	3.4%
Adult (26-59 y)	419,619	40.7%	12,114	39.2%	2.9%
Older Adult (60+ y)	150,621	14.6%	2,506	8.1%	1.7%
Ethnicity		%		%	%
African American	99,876	9.7%	4,756	15.4%	4.8%
Asian / Pacific Islander	54,615	5.3%	659	2.1%	1.2%
Caucasian	153,047	14.8%	6,271	20.3%	4.1%
Latino	596,396	57.8%	14,105	45.7%	2.4%
Native American	2,080	0.2%	124	0.4%	6.0%
Other	125,783	12.2%	4,970	16.1%	4.0%
Preferred Language		%		%	%
Cambodian	512	0.0%	9	0.0%	1.8%
English	705,640	68.4%	27,098	87.7%	3.8%
Spanish	198,474	19.2%	2,002	6.5%	1.0%
Thai	128	0.0%	7	0.0%	5.5%
Mandarin	8,332	0.4%	21	0.1%	0.3%
Vietnamese	3,254	0.3%	47	0.2%	1.4%
Other	115,501	11.2%	1,701	5.5%	1.5%
Residence Region		%		%	%
Central Valley (CV)	216,747	21.0%	5,951	19.3%	2.7%
Desert/Mountain (DM)	309,071	30.0%	11,204	36.3%	3.6%
East Valley (EV)	251,126	24.3%	7,887	25.5%	3.1%
West Valley (WV)	218,920	21.2%	4,990	16.2%	2.3%
Unknown/Out of county	35,977	3.5%	853	2.8%	2.4%

Includes all clients for DBH, contract agencies, Fee for services (FFS), outpatient, inpatient and residential.
Medi-Cal Eligible Beneficiaries: MMEF file CA Department of Health Care Services June 2025.
Medi-Cal clients served, and clients retained, unduplicated: DBH-Avatar 8/15/2025
Medi-Cal clients retained are those who receive 3 or more face-to-face visits during the fiscal year.

Medi-Cal Substance Use Disorder clients

San Bernardino County Department of Behavioral Health (DBH) served 4,992 Medi-Cal Substance Use Disorder clients in FY 2024/2025 (Table 3). An increase of 507 from the previous year.

Race/Ethnicity
Clients' race/ethnicity was as follows: 10.6% were African American, 1.3% were Asian/Pacific Islander, 32.1% were Caucasian, 52.6% were Latino, 0.5% were Native American, and 3.0% identified as Other.

Language
Clients' language preference was as follows: English 97.8%, Spanish 1.7%, and 0.5% other.

Age
Clients by age group was as follows: 0% were children (0-11 years), 2.1% were Youth (12-17 years), and 97.9% were adults and older adults (18+ years).

Gender
Clients by gender was as follows: 42.4% were female, 57.5% were male and 0.2% identified as Other.

Table 3: Substance Use Disorder Medi-Cal Indicators for Fiscal Year 2024/2025

	Medi-Cal Beneficiaries		Medi-Cal SUD Clients		Medi-Cal Penetration Rate
	1,031,841	**100.0%**	**4,992**	**100.0%**	**0.5%**
Gender		%		%	%
Female	555,070	53.8%	2,116	42.4%	0.4%
Male	476,771	46.2%	2,868	57.5%	0.6%
Other/Not Listed	0	0.0%	8	0.2%	NA
Age		%		%	%
Children (0-11 y)	209,354	20.3%	0	0.0%	0.0%
TAY (12-17 y)	116,048	11.2%	105	2.1%	0.1%
Adult/Older Adult (18+y)	706,439	68.5%	4,887	97.9%	0.7%
Ethnicity		%		%	%
African American	99,876	9.7%	527	10.6%	0.5%
Asian / Pacific Islander	54,615	5.3%	63	1.3%	0.1%
Caucasian	153,047	14.8%	1,600	32.1%	1.0%
Latino	596,396	57.8%	2,624	52.6%	0.4%
Native American	2,080	0.2%	27	0.5%	1.3%
Other	125,783	12.2%	151	3.0%	0.1%
Preferred Language		%		%	%
English	786,407	76.2%	4,881	97.8%	0.6%
Spanish	220,315	21.4%	86	1.7%	0.0%
Other	25,119	2.4%	25	0.5%	0.1%
Residence Region		%		%	%
Central Valley (CV)	216,747	21.0%	938	18.8%	0.4%
Desert/Mountain (DM)	309,071	30.0%	1,701	34.1%	0.6%
East Valley (EV)	251,126	24.3%	1,395	27.9%	0.6%
West Valley (WV)	218,920	21.2%	788	15.8%	0.4%
Unknown/Out of county	35,977	3.5%	170	3.4%	0.5%

Includes all clients for DBH, contract agencies, Fee for services (FFS), outpatient, inpatient and residential.
Medi-Cal Eligible Beneficiaries: MMEF file CA Department of Health Care Services August 2025.
Medi-Cal clients served, and clients retained, unduplicated: DBH-Avatar 8/18/2025
Medi-Cal clients retained are those who receive 3 or more face-to-face visits during the fiscal year.

2-II-B: Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Medi-Cal Eligible to Medi-Cal Mental Health Beneficiaries Served

Several disparities can be identified by comparing the Medi-Cal eligible beneficiaries' group to the Mental Health Medi-Cal clients served in FY 2024/2025.

Gender

In reference to Table 2, in terms of gender, females represent 53.8% of Medi-Cal eligible beneficiaries and only 48.6% of Medi-Cal beneficiaries served. By gender, the penetration rate was higher for males versus females (3.3% vs. 2.7%). This data does not account for individuals who identify as transgender, gender fluid or other. Other/Not listed represented 0% of clients served.

Age

In terms of age, Children represented 33.3% of beneficiaries served, compared to 27.7% of Medi-Cal eligible. Transitional Age Youth (TAY) 16-25 years represented 19.4% of beneficiaries served, compared to 17.1% of Medi-Cal eligible. Adults 26-59 years represented 39.2% of beneficiaries served, compared to 40.7% of Medi-Cal eligible. Older Adults 60+ years represented 8.1% of beneficiaries served compared to 14.6% of Medi-Cal eligible. By age group, the lowest penetration rate was for Older Adults (60+) at 1.7%, followed by Adults at 2.9%. While the penetration rates for TAY and Children were 3.4% and 3.6%, respectively.

Race/Ethnicity

In terms of Race/Ethnicity, although Latinos represented 57.8% of Medi-Cal eligible beneficiaries, they only represented 45.7% of beneficiaries served. A similar trend was found with the Asian/Pacific Islander (API) population. Although 8.6% of the total county population, 5.3% were Medi-Cal eligible and represented only 2.1% of the beneficiaries served. Further investigation is needed to identify why these two populations are using services less than other populations or are not in need of services. One area to explore is preferred language. In contrast, the opposite trend was noted with the African American, Caucasian and Native American populations. The African American group represented 9.7% of Medi-Cal eligible beneficiaries and 15.4% of beneficiaries served; Caucasians represented 14.8% of Medi-Cal eligible and 20.3% of beneficiaries served; and Native Americans 0.2% of Medi-Cal eligible and 0.4% of beneficiaries served. Native Americans have the highest penetration rate (6.0%) of all racial/ethnic groups which may be due to the fact that they are a very small percentage of the overall population.

Language

In terms of preferred languages of Medi-Cal eligible beneficiaries and Medi-Cal clients (See Table 2), 19.2% of Medi-Cal eligible beneficiaries preferred Spanish, while only 6.5% of Medi-Cal clients served preferred Spanish. Most of the Medi-Cal clients preferred English (68.4%). In comparison, 87.7% of Medi-Cal eligible beneficiaries served preferred English. The data suggests we are underserving the Spanish speaking Medi-Cal population. The penetration rate for the preferred Mandarin language group was 0.3%, the lowest for all the language groups. The second lowest penetration rate was for the preferred Spanish language group (1.0%).

Medi-Cal Eligible to Medi-Cal Substance Use Disorder Beneficiaries Served

Several disparities can be identified by comparing the Medi-Cal eligible beneficiaries' group to the Substance Use Disorder Medi-Cal clients served in FY 2024/2025.

Gender

In terms of gender, fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (42.4% versus 53.8%). In contrast, 57.5% of Medi-Cal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 46.2%. By gender, the penetration rate was higher for males versus females (0.6% vs. 0.4%).

Age

In terms of age, Adults (18+ years) represented 97.9% beneficiaries served compared to 68.5% Medi-Cal eligible. Youth (12-17 years) represented only 2.1% of beneficiaries served, compared to 11.2% of Medi-Cal eligible. The percentages of Children served was zero (0) compared to the percentages of the Medi-Cal eligible population of 20.3%. The data is interpreted as Youth and Children being underserved and unserved.

Race/Ethnicity

In terms of Race/Ethnicity, although Latinos represented 57.8% of Medi-Cal eligible beneficiaries, they only represented 52.6% of beneficiaries served. A similar trend was found with the Asian/Pacific Islander population. Although 5.3% of Medi-Cal eligible, they represented only 1.3% of the beneficiaries served. Further investigation is needed to identify why these two populations are using services less than other populations or are not in need of services. One area to explore is preferred language. In contrast, the opposite trend was noted with the Caucasian and Native American populations. Caucasians represented 14.8% of Medi-Cal eligible beneficiaries and 32.1% of beneficiaries served. Native Americans represented 0.2% of Medi-Cal eligible and 0.5% of beneficiaries served. Native Americans have the highest penetration rate (1.3%) of all racial/ethnic groups, but this may be due to the fact they are a very small percentage of the overall population.

Language

In terms of preferred languages of Medi-Cal eligible beneficiaries and Medi-Cal clients (See Table 3), 21.4% of Medi-Cal eligible beneficiaries preferred Spanish, while only 1.7% of Medi-Cal clients served preferred Spanish. The vast majority of Medi-Cal clients served preferred English (97.8%). In comparison, 76.2% of Medi-Cal beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population.

2-III: 200% of Poverty (minus Medi-Cal) Population and Service Needs.

2-III-A: Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender.

Table 4: Population Under 200% FPL Minus Medi-Cal Eligible Beneficiaries Fiscal Year 2024/2025

Population under 200% of Federal Poverty Line:	702,596
Medi-Cal Eligible Beneficiaries:	1,031,841
Population under 200% FPL minus Medi-Cal Eligible Beneficiaries:	(329,245)

Sources: Population under 200% FPL is based off ratios calculated from U.S. Census Bureau, U.S. Department of Commerce. "Poverty Status in the Past 12 Months." American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1701, https://data.census.gov/table/ACSST1Y2023.S1701?q=federal+poverty+level&g=010XX00US_050XX00US06071. Accessed on 8/14/2025.

Table 5: San Bernardino Population Under 200% of the Federal Poverty Line, Medi-Cal Beneficiaries, and Mental Health Medi-Cal Clients Served and Non Medi-Cal Clients Served Fiscal Year 2024/2025

	Population under 200% FPL		Medi-Cal Beneficiaries		Medi-Cal Clients Served		Non Medi-Cal Clients Served	
	702,596	100.0%	1,031,841	100.0%	43,481	100.0%	7,948	100.0 %
Gender		%		%		%		%
Female	351,580	50.0%	555,070	53.8%	20,604	47.4%	3,684	46.4%
Male	351,015	50.0%	476,771	46.2%	22,638	52.1%	4,213	53%
Other/Not listed	0	0%	0	0.0%	239	0.5%	51	0.6%
Age Group		%		%		%		%
Children (0-15y)	154,605	22.0%	285,372	27.7%	12,879	29.6%	2,567	32.3%
TAY (16-25y)	102,141	14.5%	176,229	17.1%	8,120	18.7%	1,783	22.4%
Adult (26-59y)	316,003	45.0%	419,619	40.7%	19,130	44%	3,067	38.6%
Older Adult (60+y)	129,846	18.5%	150,621	14.6%	3,352	7.7%	531	6.7%
Ethnic Group		%		%		%		%
African American	53,030	7.5%	99,873	9.7%	6,3796	14.7%	1,182	14.9%
Asian/Pacific Islander	60,103	8.6%	54,615	5.3%	917	2.1%	99	1.2%
Caucasian	168,254	23.9%	153,047	14.8%	9,368	21.5%	1,611	20.3%
Latino	392,408	55.9%	596,396	57.8%	19,765	45.5%	3,193	40.2%
Native American	1,902	0.3%	2,080	0.2%	169	0.4%	21	0.3%
Other/Unknown	26,898	3.8%	125,7837	12.2%	6,886	15.8%	1,742	21.9%
Region		%		%		%		%
Central Valley	140,519	20.0%	216,747	21.0%	8,453	19.4%	1,718	21.6%
Desert/Mountain	175,649	25.0%	309,071	30.0%	114,976	34.4%	2,235	28.1%
East Valley	161597	23.0%	251,126	24.3%	10,484	24.1%	1,380	17.4%
West Valley	224,831	32.0%	218,920	21.2%	5,6497,303	16.8%	1,548	19.5%
Other/Unknown	0	0.0%	35,977	3.5%	2,265	5.2%	1,067	13.4%

Language**								
Cambodian							0	0.0%
English							6,367	80.1%
Spanish							522	6.6%
Thai							0	0.0%
Vietnamese							5	0.1%
Mandarin							14	0.2%
Other							522	6.6%

Includes all clients for DBH, contract agencies, Fee for services (FFS), outpatient, inpatient and residential.
Medi-Cal Eligible Beneficiaries: MMEF file CA Department of Health Care Services August 2025. Population under 200% FPL is based off ratios calculated from U.S. Census Bureau, U.S. Department of Commerce. "Poverty Status in the Past 12 Months." American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1701, https://data.census.gov/table/ACSST1Y2023.S1701?q=federal+poverty+level&g=010XX00US_050XX00US06071. Accessed on 8/14/2025.
Medi-Cal clients served, and clients retained, unduplicated: DBH-Avatar 8/18/2025
Medi-Cal clients retained are those who receive 3 or more face-to-face visits during the fiscal year.
***County Preferred Language data on preferred language is unavailable.*

2-III-B: Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Comparison of Medi-Cal Clients Served FY 2024/2025 to County Population under 200% of FPL:

Gender
The percentage of Medi-Cal female clients served was at 47.4% less than the females under 200% of the federal poverty line (FPL) of 50.0%. The percentage of Medi-Cal male clients served was higher at 52.1% than males under 200% FLP at 50.0%.

Age
The percentages of children (0-15 years) were higher in the Medi-Cal clients served group at 29.6% compared to the population in poverty at 22.0%. The percentage of TAY (16-25 years) was higher in the Medi-Cal clients served group at 18.7% compared to the population in poverty at 14.5%. The percentage of Medi-Cal Adult clients served was lower at 44% compared to the population in poverty at 45.0%. The percentage of older adult clients (60+ years) served was lower at 7.7% compared to the older adult population in poverty at 18.5%.

Race/Ethnicity
The percentages of African Americans/Black were higher in the Medi-Cal clients served group compared to the population under 200% of FPL. African Americans were 7.5% of the population in poverty, and 14.7% of the Medi-Cal clients served group. In contrast, the percentages of Asian/Pacific Islanders (API), Latino and Caucasian groups were lower in the Medi-Cal Clients served group compared to the population under 200% of FPL. The percentages of API Medi-Cal clients served was 2.1% compared to 8.6% of the population in poverty. The percentage of Latino Medi-Cal clients served was 45.5% compared to the 55.9% of the population in poverty. The percentage of Caucasian Medi-Cal clients served was 21.5% compared to the 23.9% of the population in poverty.

Comparison of Non Medi-Cal Clients Served in Fiscal Year 2024/2025 to County Population under 200% of FPL:

Gender

The percentage of Non Medi-Cal females served was at 46.4%, less than the females under 200% of FPL, 50.0%. The percentage of Non Medi-Cal males 53% was higher than males under 200% FPL (50.0%).

Age

Children (32.3%) and TAY (22.4%) Non Medi-Cal clients served were higher than Children (22.0%) and TAY (14.5%) under 200% of FPL. Non Medi-Cal Adults (38.6%) and Older Adults clients (6.7) were served at lower percentages than Adults (45.0%) and Older Adults (18.5%) under 200% of FPL.

Race/Ethnicity

The majority of Non Medi-Cal clients served was Latino at 40.2% but still lower than the percentage of Latinos under 200% of FPL (55.9%). The data shows a similar trend for Asian/Pacific Islanders, and Caucasians. African Americans/Black clients were served at a higher percentage 14.9% than African American/Black individuals under 200% of FPL (7.5%).

2-IV: MHSA Community Services and Supports (CSS) Population Assessment and Service Needs.

2-IV-A: From the CSS component of the county's approved Three-Year Program and Expenditure Plan (Plan), extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender.

Table 6: MHSA CSS Fiscal Year 2024/2025

	Clients Served		County Population (*)
Total	14,038	100%	100%
Gender		**%**	**%**
Female	6,530	46.52.%	50.0%
Male	7,433	52.95%	50.0%
Other/Not listed	75	0.53%	0.0%
Age		**%**	**%**
Children (0-15 y)	2,928	20.86%	22.0%
Young Adult (16-25y)	3,116	22.20%	14.5%
Adult (26-59y)	6,777	48.285%	45.0%
Older Adult (60+y)	1,217	8.67%	18.5%
Ethnicity		**%**	**%**
African American/Black	2,735	19.48%	7.5%
Asian/Pacific Islander	335	2.39%	8.6%
Caucasian	3,499	24.93%	23.9%
Latino	5,980	42.60%	55.9%
Native American	65	0.46%	0.3%

Other/Unknown	1,424	10.14%	3.8%
Preferred Language**		**%**	**%**
Cambodian	1	0.01%	
English	12,955	92.29%	
Spanish	586	4.17%	
Thai	6	0.04%	
Mandarin	17	0.12%	
Vietnamese	4	0.03%	
Other	469	3.34%	
Residence Region		**%**	**%**
Central Valley (CV)	3,102	22.10%	20.0%
Desert/Mountain (DM)	4,481	31.92%	25.0%
East Valley (EV)	3,701	26.36%	23.0%
West Valley (WV)	1,860	13.2%	32.0%
Unknown/Out of county	894	6.374%	0.0%

Sources: Total Population (*): California Department of Finance and Demographic Research Unit
Unduplicated Clients Served: MyAvatar 8/2025
MHSA-CSS unduplicated consumers served based on RUs associated to the MHSA program
***County Preferred Language data on preferred language is unavailable.*

In FY 2024/2025, San Bernardino County DBH served 14,038 clients through the MHSA Community Services and Support (CSS) Programs. An increase of 195 from the previous year.

Gender
Females represented 46.52% of clients, and males 52.95%.

Age
Adults between the ages of 26 and 59 represented 48.28% of clients. Clients ages 16 to 25 represented 22.20% of clients. Children ages 0 to 15 represented 20.86% of clients. Older Adults had the lowest percentage at 8.67% clients.

Race/Ethnicity
In terms of race/ethnicity, most clients identified as Latino 42.60% followed by Caucasian 24.93% and African American/Black 19.48%. Asian/Pacific Islanders represented 2.39% of clients and Native Americans represented 0.46%.

Language
The vast majority of CSS consumers preferred to speak English (92.29%) while 4.17% preferred Spanish.

2-IV-B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Gender
The proportion of females and males in the MHSA-CSS unduplicated clients served vary from the county population. The county male population is the same as the county female population at 50.0% whereas the female population for the unduplicated clients served comes in at only 48.1% allowing the male unduplicated population the majority at 51.3%. This data does not account for

individuals who identify as transgender, gender fluid or other. Other/Not listed represented 0.6% of clients served.

Age

The percentage of children (0-15 years old) in the CSS program 20.867% is just smaller than its proportion of the county population 22.0%. The percentage of Transitional Age Youth (16-25 years) in the CSS programs was higher compared to the percentage of the county population 22.2% vs. 14.5% respectively. Older adults (60+ years) are underrepresented at 8.67% in the CSS programs compared to their 18.5% proportion of the county population.

Race/Ethnicity

The percentage of African American/Black in the CSS programs is higher compared to their proportion of the county population (19.48% vs. 7.5%). The percentage of Asian/Pacific Islanders in CSS programs is lower than all other groups (2.39%). The percentage of Latinos in CSS programs is also lower when compared to their proportion of the population 42.60% vs. 55.92%. The percentage of Caucasian is lower in CSS programs compared to their proportion of the county population (24.93% vs. 23.9%). Native Americans constitute 0.3% of the county Population and have a representation, of 0.46%, in CSS programs. CSS consumers who identified as Other/Unknown ethnicity were overrepresented 10.14%, compared to their proportion of the county population (3.8%).

2-V. Prevention and Early Intervention (PEI) Plan: The Process Used to Identify the PEI Priority Populations

2-V-A: Which PEI Priority Population(s) did the county identify in the PEI component of its Plan?

The county could choose from the following seven PEI Priority Populations:

1. **Underserved cultural populations**
2. **Individuals experiencing onset of serious psychiatric illness**
3. **Children/youth in stressed families**
4. **Trauma-exposed**
5. **Children/youth at risk of school failure**
6. **Children/youth at risk or experiencing juvenile justice involvement**
7. **Individuals experiencing co-occurring substance abuse issues**

San Bernardino County utilized an extensive community planning process to select the original PEI priority populations that included targeted community forums, as well as a community survey. Sixty-two (62) Targeted community forums were conducted with the general community as well as an extensive listing of Community Based Organizations**.** Advertisements of the forums were developed with a number of media outlets including; radio (Radio Mexico), internet sites, print (brochures and flyers in English, Spanish, and Vietnamese) and newspapers which included: Black Voice, Big Bear Grizzly, Crestline Chronicles, Daily Bulletin (West Valley), Desert Trails, Fontana Herald Press, Press Enterprise, San Bernardino Sun, Daily Journal, Lucerne Leader, Colton City News, Needles Desert Star, Redlands Daily Facts, Senior Newspaper, and Yucaipa News Mirror.

A Community Service Needs Survey was developed to share ideas, approach strategies, and define priorities related to multiple PEI needs in the communities served. A total of eight hundred and ninety-six (896) were received; three hundred and ninety-seven (397) in Web format and four

hundred and ninety-nine (499) in paper design. Additionally, demographic data was solicited in English, Spanish and Vietnamese at the targeted forums via a Demographic Data Collection form to ensure an inclusive community process. 96% of these forms were completed by English speakers, 3% by Spanish speakers and 1% by Vietnamese speakers. 70% of the respondents identified as female and 30% as male, with the largest age group being adults (70%), followed by older adults (15%), TAY (8%) and children (2%). Ethnicity of respondents included Caucasians (33%), Latinos (30%), African Americans (17%), Native Americans (5%) and Asian/Pacific Islanders (3%). Per the Community Service Needs Survey, and the targeted community forums, community members identified the following as priority PEI populations:

1. Children/Youth at Risk for Juvenile Justice Involvement 51%
2. Early signs of serious Mental Illness ("first break") 50%
3. Children/Youth at Risk for School Failure 49%
4. Suicide Prevention 49%
5. Children & Youth in Stressed Families 47%
6. Trauma Exposed Individuals 41%
7. Stigma & Discrimination Related to Mental Illness 41%
8. Underserved Cultural Populations 34%

Based on the overall community input, the targeted PEI populations were identified, understanding that Stigma and Discrimination and Suicide (items #7 and #4 above) would be addressed at the State level via PEI statewide projects.

On October 6, 2015, updated PEI Component Regulations became effective. The updated regulations designed by the Mental Health Oversight and Accountability Commission (MHSOAC) changed the framework and structure of the PEI component as compared to the guidance received via DMH-IN 07-19.

Most of the changes related to restructuring principles and concepts. The principles are now parceled out as individual programs. A program is defined in the new regulations as "a stand-alone organized and planned work, action, or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at-risk of serious mental illness or for the mental health system (WIC §3701 (b))." Currently, there are six (6) State-Defined Prevention and Early Intervention Programs: Stigma and Discrimination Reduction, Outreach for Increasing Recognitions of Signs of Mental Illness, Access and Linkage to Treatment, Prevention, Early Intervention, and Suicide Prevention. Additionally, all Programs must include the following three (3) strategies as part of their programing: Access and Linkage, Improve Timely Access and Reduce and Circumvent Stigma.

Prior to the finalization of the PEI regulations, DBH conducted a robust community planning process to evaluate the current structure and framework of the PEI component as compared to the new State Program categories. Stakeholders were given the new categories and definitions and asked to determine which new required program reporting category best aligned with the existing PEI program(s) by making their selection on the form. They were also asked to determine if the required strategies were already contained within each program. Stakeholder groups reached a consensus that the existing PEI Component program met the Program and Strategy requirements of the new regulations.

As a result of DBH's collaboration with stakeholders, implementation of the PEI Component now exists under the reporting construct below:

- Stigma and Discrimination Reduction: Native American Resource Center
- Outreach for Increasing Recognitions of Signs of Mental Illness: Promotores de Salud/Community Health Workers and Substance Use Prevention and Pathways to Outreach and Treatment.
- Access and Linkage to Treatment: Child and Youth Connection
- Prevention: Preschool PEI Program, Resilience Promotion in African American Children, LIFT, Coalition Against Sexual Exploitation, and Older Adult Community Services
- Prevention and Early Intervention: Student Assistance Program, Family Resource Center, Military Services and Family Support, and Community Wholeness and Enrichment
- Early Intervention: Early Psychosis Program
- Suicide Prevention: DBH continues to participate in the PEI statewide Suicide Prevention project administered by CalMHSA.

In September of 2018, California Senate Assembly Bill 1004 was approved by the Governor. The bill requires the MHSOAC to establish priorities for the use of Mental Health Services Act PEI funds, as specified, and to develop a statewide strategy for monitoring the implementation and effectiveness of PEI program, as specified. The bill will standardize and improve PEI programs ensuring access to effective, quality care in counties across the state.

The bill establishes specific priorities for the use of PEI funds. These priorities include:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
2. Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
4. Culturally competent and linguistically appropriate prevention and intervention.
5. Strategies targeting the mental health needs of older adults.
6. Other programs the commission identifies, with stakeholder participation that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

In alignment with the revised PEI priorities, DBH organized the existing PEI programs to correspond with these updated priorities. These priorities have been seamlessly integrated into our MHSA plan, maintaining consistency with our previously established strategies as part of our community planning process. Below, you will find a representation of the priorities alongside the programs that address each of them.

- Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
    - Child and Youth Connection
    - Preschool PEI Program
    - Coalition Against Sexual Exploitation
    - Family Resource Center
    - Student Assistance Program
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
    - Community Wholeness and Enrichment
    - Improving Detection and Early Access

- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
    - Resilience Promotion in African American Children
    - Coalition Against Sexual Exploitation
    - Community Wholeness and Enrichment
    - Student Assistance Program
- Culturally competent and linguistically appropriate prevention and intervention.
    - Native American Resource Center
    - Community Health Worker/Promotores de Salud
    - Resilience Promotion in African American Children
    - Military Services and Family Support
- Strategies targeting the mental health needs of older adults.
    - Older Adult Community Services
- Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.
    - Substance Use Prevention & Pathways to Outreach and Treatment
    - Preschool PEI Program
    - Lift Program
    - Family Resource Center
    - Military Services and Family Support

CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES
CLAS Standards: 1, 10 & 14

3-I: List the Target Populations with Disparities your County Identified in Medi-Cal and all MHSA Components (Medi-Cal, CSS, WET, and PEI Priority Populations).

Medi-Cal Target Population(s) with Disparities:

The San Bernardino County Medi-Cal population for FY 2024/2025 includes 1,031,841 beneficiaries.

Disparities can be identified in all Racial/Ethnic Populations for Mental Health.

Asian Pacific Islanders and Latino populations were served at lower percentages when compared to other Medi-Cal eligible populations. Native Americans were less than one percent of Medi-Cal eligible, and less than one percent of beneficiaries served in FY 2024/2025. They were a very small percentage of the overall county population, a very small percentage of the Medi-Cal population but were served at the highest penetration rate (6.0%). This can be interpreted as an overrepresentation of Native Americans among beneficiaries served, despite their small numbers overall.

In terms of age, Older Adults (60+) had the lowest penetration rate of all age populations groups (1.7%).

In terms of preferred languages 19.2% of Medi-Cal eligible beneficiaries preferred Spanish, while only 6.5% of Medi-Cal clients served preferred Spanish. Most of the Medi-Cal clients preferred

English (87.7%). In comparison, 68.4% of Medi-Cal beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population. The penetration rate for the preferred Spanish language group was 1.0%.

CSS Population with Disparities:

The CSS population in FY 2024/2025 included 14,038clients. Of this population, disparities can be seen in the Children (0-15 years old), Older Adult (60+ years old), Asian Pacific Islander, and Latino populations. All were served at lower percentages when compared to their percentage in the county overall population. The African American and the Young Adults (16-25 years old) populations, were served at higher percentages when compared to their percentage in the county overall population.

WET Population with Disparities:

DBH employed 1,600 employees as of the end of June 2025, 90 more than the previous year fiscal year. Disparities in the workforce regarding race/ethnicity exist for the Latino population when compared to their percentage to the overall county general population (45.1% vs. 55.9%). In terms of gender males make up 2.44% of the workforce, significantly less than their percentage in the overall county population (50%). In terms of language, DBH employed 291 bilingual staff as of the end of June 2025. This represents 18.2% of the workforce, which is lower than the Medi-Cal beneficiary preferred language of 19.2%.

PEI Population Priority Populations:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs and substance use disorder needs.
2. Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
4. Culturally competent and linguistically appropriate prevention and intervention.
5. Strategies targeting the mental health and substance use disorder of older adults.
6. Strategies addressing needs of individuals at high risk of crisis.
7. Other programs are aligned consistent with our community planning process that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

SUD Medi-Cal Population with Disparities:

The SUD Medi-Cal population in FY 2024/2025 included 4,992 clients. Of this population, disparities can be seen in the Children and Youth, Asian and Pacific Islander and Latino populations. These populations were served at lower percentages when compared to their percentages as Medi-Cal beneficiaries. In contrast, the Caucasian and Adult (18+) populations are served at significantly higher percentages than their percentage of Medi-Cal beneficiaries. In terms of preferred languages, 21.4% of Medi-Cal eligible beneficiaries preferred Spanish, while only 1.7% of Medi-Cal clients served preferred Spanish. The vast majority of Medi-Cal clients served preferred English (97.8%). In comparison, 76.2% of Medi-Cal beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population.

3-I-A: From the above identified PEI Priority Population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities).

As noted in Criterion 2, the County of San Bernardino (County), Department of Behavioral Health (DBH) and community stakeholders embarked on an extensive community planning process to identify priorities and strategies and to develop concepts to be included in the PEI Component Plan for approval by the State.

3-II: Identified Disparities (Within the Target Populations)

3-II-A: List disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

Medi-Cal Population Mental Health:

As previously described above disparities exist in San Bernardino County for specific populations.

Asian/Pacific Islanders (API) are underrepresented in behavioral health services, meaning they are served in DBH at a percentage that is lower than their percentage in the Medi-Cal beneficiary population, 2.1% vs. 5.3%. The API population has the lowest penetration rate at 1.2%.

For Latinos, there is a lack of access and service utilization in general, having a penetration rate at 2.4% and being the largest Medi-Cal beneficiary population at 57.8%.

African Americans represented 9.7% of Medi-Cal beneficiaries and 15.4% of beneficiaries served by DBH. African Americans have a penetration rate of 4.8%.

Caucasians represented 14.8% of Medi-Cal beneficiaries and 20.3% of beneficiaries served by DBH. Caucasians have a penetration rate of 4.1%.

Native Americans were less than one percent (0.2%) of Medi-Cal eligible, and less than one percent (0.4%) of beneficiaries served. However, this can also be interpreted as an overrepresentation of Native Americans among beneficiaries served, despite their small numbers overall. They were a very small percentage of the overall county population, a very small percentage of the Medi-Cal population but were served at the highest penetration rate (6.0%).

When examining the Medi-Cal population by age, Older Adults have the lowest penetration rate at 1.7%. Followed by Children at 3.6% and TAY 3.4%. Adults (26-59) have the highest penetration rate at 2.9%.

When examining the Medi-Cal population by preferred language, the penetration rate for the preferred Spanish language group was 1.0%.

CSS Population:

For the Community Services and Support (CSS) Population, disparities in access to services can be seen among older adults (60+ years old). While older adults constitute 18.5% of the county population, they are only 8.67% of CSS clients.

Disparities in access to services can be seen Asian and Pacific Islanders, and Latinos pointing to racial/ethnic disparities in access to services. Asian and Pacific Islanders constitute 8.6% of the county population they were only 2.39% of CSS clients. Latinos constitute 55.9% of the county population, they were only 42.60% of CSS clients.

In contrast the percentages of African Americans served in CSS programs were higher than the general population at 19.48% vs. 7.5%.

WET Population:

Latinos, comprise majority of the San Bernardino County population (55.9%), and the Medi-Cal funded population (57.8%). In FY 2024/2025, Latinos represented 45.1% of the DBH workforce.

In FY 2024/2025, there were two hundred and ninety one (291) bilingual staff members, the majority of whom spoke Spanish (98.6%). DBH in collaboration with the Human Resources Department continue to actively recruit bilingual staff. This represents 18.2% of the workforce, lower than the Medi-Cal beneficiary preferred language of 19.2%.

PEI Population:

In September of 2018, California Senate Assembly Bill 1004 was approved by the Governor. The bill requires the MHSOAC to establish priorities for the use of Mental Health Services Act PEI funds, as specified, and to develop a statewide strategy for monitoring the implementation and effectiveness of PEI program, as specified. The bill will standardize and improve PEI programs ensuring access to effective, quality care in counties across the state.
The bill establishes specific priorities for the use of PEI funds. These priorities include:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
2. Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
4. Culturally competent and linguistically appropriate prevention and intervention.
5. Strategies targeting the mental health needs of older adults.
6. Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

In alignment with the revised PEI priorities, DBH organized the existing PEI programs to correspond with these updated priorities. These priorities have been seamlessly integrated into our MHSA plan, maintaining consistency with our previously established strategies as part of our community planning process as previously discussed in Criterion 2.

3-III: Identified Strategies/Objectives/Actions/Timelines

3-III-A: List the strategies identified for the Medi-Cal population as well as those strategies identified in the MHSA plan for CSS, WET, and PEI components for reducing the disparities identified.

Medi-Cal strategies to address and reduce disparities in service and access include the following programs:

San Bernardino County is geographically the largest county within the United States. DBH provides access to behavioral health services through an extensive network of county operated clinics, contracted provider agencies, and a fee-for-service network in each region of the county. Addressing disparities in access are addressed on multiple levels. Providers are contractually required to participate in Cultural Competency trainings, provide culturally and linguistically appropriate services, and are subject to test calls and mystery shopper calls that test the effectiveness of information delivery, customer service and language access services.

- In the Latino community, there is a lack of access and service utilization in general, having the second lowest penetration rates for a population that is the largest in the county as well as the largest in the Medi-Cal funded population. To address this, DBH has worked and continues to work with CBOs (community-based organizations) to develop a curriculum for use in Community Health Worker and Promotores de Salud (CHW/PdS) programs. The focus of these programs is to train community members intrinsic to the local communities on behavioral health as well as resources available and how to access them. The curriculum is reviewed and updated by CBOs and DBH as needed to ensure information is up to date and appropriate for the target population. These same CBOs also provide a continuum of behavioral health services and have requisite knowledge of community resources to support this population. In addition, the Office of Equity and Inclusion (OEI) partners with the Cultural Competency Advisory Committee (CCAC) Latino Awareness Subcommittee to develop and implement educational and cultural events throughout the year, assisting in building trust in the community.
- In the African American community, DBH has worked with the African American Health Coalition in the development of a Community Health Worker (CHW) curriculum to address access and utilization of appropriate services. CHWs provide education and outreach and system navigation services for this population. The curriculum is reviewed and updated by CBOs and DBH as needed to ensure information is up to date and appropriate for the target population. In addition, OEI partners with the CCAC African American Awareness Subcommittee to support symposiums and cultural events throughout the year, assisting in building trust in the community.
- The Resilience Promotion in African American Children (RPiAAC) program is a Prevention and Early Intervention program that targets African American children and youth. The RPiAAC program embraces African American values, beliefs, and traditions, and incorporates the culture into educational behavioral health services. The goal of the program is to promote resilience in African American children to reduce the risk factors that lead to the development of a mental illness and/or substance use disorders.
- In the Asian/Pacific Islander community, DBH has worked with the Asian American Resource Center in the development of a Community Health Worker (CHW) Curriculum to address the lack of access to services and educate on appropriate service utilization. The Asian/Pacific Islander population has the lowest penetration rate of all racial/ethnic groups.

CHWs provide education and outreach and system navigation services for this population. The curriculum is reviewed and updated by CBOs and DBH as needed to ensure information is up to date and appropriate for the target population. In addition, OEI partners with the CCAC Asian and Pacific Islander Awareness Subcommittee to support educational and cultural events throughout the year, assisting in building trust with this community.

- For the Native American community, DBH has worked with Riverside San Bernardino County Indian Health, Inc. in the development of a Community Health Worker (CHW) Curriculum to address access to services and educate on appropriate service utilization. CHWs provide education and outreach and system navigation services for this population. The curriculum is reviewed and updated by CBOs and DBH as needed to ensure information is up to date and appropriate for the target population. In addition, OEI partners with the CCAC Native American Awareness subcommittee to support educational and cultural events throughout the year, assisting in building trust with this community.
- The Department of Behavioral Health (DBH) offers the Older Adult Community Services (OACS) program, which supports individuals aged 60 and above who may be at risk of developing mental health concerns. The program is designed to address key risk factors such as depression, social isolation, chronic health conditions, and limited family support. During intake, OACS utilizes assessment tools to identify risks related to suicide, health concerns, social supports, and depression, ensuring participants are connected to the most appropriate services. In addition, OEI partners with the CCAC Older Adult Awareness subcommittee to support educational and cultural events throughout the year, assisting in building trust with this community.

CSS strategies to address and reduce disparities in service and access include the following programs:

DBH currently has nine (9) Full-Service Partnership (FSP) programs that address the needs of specific populations and age groups. FSP programs are designed for consumers who have been diagnosed with a serious mental illness or serious emotional disturbance and would benefit from an intensive program. FSP services comprehensively address client and family needs and do "whatever it takes" to meet those needs, including supports and strong connections to community resources with a focus on resilience and recovery. FSP programs implement key practices that consistently promote good outcomes for mental health clients and their families that differ from traditional, clinic-based outpatient care due to the 24 hour per day, 7 days per week available support.

In FY 2024/2025, FSP programs served 5,862 unduplicated consumers in the FSP service category.

FSP programs:

- The Age Wise program provides Full-Service Partnership (FSP) behavioral health and case management services throughout San Bernardino County to older adults living with the most severe mental health diagnoses. Age Wise works to increase access to services for the older adult community and decrease the stigma associated with the behavioral health and wellness system. Age Wise program services are provided through the San Bernardino County Department of Aging and Adult Services – Public Guardian (DAAS-PG).
- The Comprehensive Children and Family Support Services (CCFSS) program uses the Integrated Core Practice Model (ICPM) and provides services to children and youth living

with serious emotional disturbance (SED) or intensive mental health needs. CCFSS provides culturally competent "wraparound" services to children and their families in their natural environment in order to achieve a positive set of outcomes through unconditional care. The target population for this program is children (ages 0-15) and TAY (ages 16-25) living with Serious Emotional Disturbance and/or Serious Mental Illness who have Probation or CFS involvement. CCFSS is comprised of three unique Full-Service Partnership (FSP) subprograms. The three individualized and targeted FSP subprograms are:

  - Children's Residential Intensive Services (ChRIS)
  - SB163 Wraparound
  - Success First/Early Wrap

  All CCFSS subprograms utilize the Therapeutic Behavioral Services (TBS) program as a short-term service to provide comprehensive community-based services to children and their families, one-on-one coaching, and develop tailored service plans that focus on individual strengths. Each subprogram is designed to assist children and youth in avoiding out-of-home placements or loss of current placement due to the severity of their emotional disturbance

- The One Stop Transitional Age Youth (TAY) Centers provide integrated services to the unserved, underserved, and inappropriately served TAY population in the County of San Bernardino. These youth may be emotionally disturbed, with significant functional impairment, severely and persistently mentally ill or at-risk of mental health issues, high users of acute facilities, homeless or at risk of being homeless (caused by an existing out of home placement), have co-occurring disorders, and have a history of incarceration, institutionalization, and recidivism.

  The One Stop TAY Centers are mental health clinics modeled as drop-in centers to improve TAY participation and allow TAY to utilize the services needed to maximize their individual potentials through the Recovery, Wellness, and Resiliency Model, while already in the community, and prepare for re-entry into the community. One Stop TAY Centers, in partnership with the Departments of Probation, Children and Family Services, and numerous community partners, assist TAY in achieving their goals of becoming independent, staying out of the hospital or higher levels of care, reducing involvement in the criminal justice system, and reducing homelessness.
  The target population for the program is youth (ages 16-25) under 200% of the federal poverty level with or at-risk of mental health issues. Two of the targeted sub-populations are Latinx/Hispanic and African American/Black youth who are disproportionately over-represented in the justice system and out-of-home placements (Foster Care, group homes, and institutions).
- Integrated New Family Opportunities (INFO) is a National Association of Counties (NACo) and Counsel on Mentally Ill Offenders (COMIO) award-winning program that uses intensive probation supervision and evidence-based Functional Family Therapy (FFT). The goal is to provide and/or obtain services for children/youth and their families that are unserved or underserved. The program works with the juvenile justice population, ages 13-17, and their families. Services provided by INFO increase family stabilization, help families identify community supports, and encourage recovery, wellness, and resiliency.

- The Forensics Services Continuum of Care program is designed to serve adults living with severe mental illness (SMI) who are involved in the criminal justice system. The program consists of eight (8) sub-programs designed to target specific populations.
    - Supervised Treatment After Release (STAR)
    - Community Supervised Treatment After Release (CSTAR)
    - Joshua Tree Mental Health Court (JTMHC)
    - Forensic Assertive Community Treatment (FACT)
    - Community Forensic Assertive Community Treatment (CFACT)
    - Corrections Outpatient Recovery Enhancement (CORE)
    - Choosing Healthy Options to Instill Change and Empowerment (CHOICE)Re-Integrative Supportive Engagement Services (RISES)
- The Assertive Community Treatment (ACT) Model Full-Service Partnership (FSP) Services program serves San Bernardino County resident adults,18 years and older, living with a behavioral health condition. This program exists to assist consumers in living successfully within the community and support positive progress toward achieving individual personal recovery goals, while avoiding unnecessary psychiatric hospitalization. The program consists of two sub-programs: the Assertive Community Treatment (ACT) program and the Members Assertive Positive Solutions (MAPS) program.

  The Assertive Community Treatment (ACT) program serves consumers transitioning from institutional settings, such as State Hospitals, Institutions for Mental Disease (IMDs), or locked psychiatric facilities. The Members Assertive Positive Solutions (MAPS) program serves consumers who are historically high users of acute psychiatric inpatient and crisis services. These consumers may also have a history of a co-occurring substance use disorder (SUD) or a history of identifying as homeless.

  The Recovery Model used for both programs builds on traditional Assertive Community Treatment standards. The program approach is based on the belief that "recovery can happen," creating an environment that promotes personal resiliency. Key components of the ACT model are treatment and support services that are individualized and guided by the consumer's hopes, dreams, and goals for behavioral health and overall wellness.

- Regional Adult Full-Service Partnership (RAFSP) offers Full-Service Partnership (FSP) programs in the Department of Behavioral Health's Barstow, Phoenix, Mesa, Mariposa, and Victor Valley community clinics. Additionally, DBH contracts FSP services with Mental Health Systems, Inc., Step Up on Second and Valley Star Behavioral Health, Inc., to provide additional FSP services throughout San Bernardino County. The RAFSP programs provide access and linkage, as well as full wraparound care to consumers. These services include intensive clinic and field-based services that assist individuals in accessing various levels of care and housing, and/or step down to a lower level of care in the least restrictive setting possible. Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive treatment and intensive case management support.
- The Collaborative Adult FSP Services program is a component under MHSA. It consists of the Community Reintegration Services (CRS) program and the Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program.
- The Community Reintegration Services (CRS) program is a Full-Service Partnership designed to serve adults who are living with severe mental illness or untreated co-occurring

disorders who, in many cases, have recently been released from State Hospitals and/or psychiatric facilities. These adults are at imminent risk of homelessness, incarceration, hospitalization, or re-hospitalization. Services utilize a strengths-based approach by focusing on the consumer's strengths and goals to move towards a new level of functioning in the community. Additionally, CRS embraces a consumer-centered approach that ensures that each consumer's needs are met based on where the consumer is in the process of recovery. The Recovery Based Engagement Support Team – Assisted Outpatient Treatment (AOT) program. AOT is court-ordered outpatient treatment for individuals who have a history of untreated mental illness and meet criteria as stipulated in WIC 5345-5349.5. The program is intended to interrupt the cycle of hospitalization, incarceration, and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis.

- Housing and Homeless Services Continuum of Care Program (HHSCCP) is a robust continuum of care of services for individuals that are at-risk of homelessness, chronically homeless, or are homeless and living with a serious mental illness and/or substance use disorder. HSCCP is comprised of Homeless Outreach Support Team (HOST), Full-Service Partnership, InnRoads and Supportive Services.

Recovery Based Engagement Support Teams (RBEST) a voluntary, consumer-centered program which provides community (field-based) services to individuals living with untreated or inappropriately treated mental illness that strives to connect and activate them into treatment. RBEST is not a treatment model and does not provide endless mobile services to identified consumers. The program is "non-clinical" in its orientation with a primary focus on meeting the needs and supporting the goals of the consumer and helping that consumer eliminate obstacles. Multidisciplinary engagement teams provide a holistic, highly flexible approach that is based on the needs of each consumer. RBEST staff provide an opportunity for shared decision making in an unstructured, field-based environment when presenting treatment options to consumers and families, encourages deliberation, and elicit possible care preferences. RBEST offers family support through the Connecting Families support group. Connecting Families provide families with support, education and empowerment to continue caring for their loved ones in their community.

Clubhouses are peer-driven support centers for members in recovery. Members may or may not be receiving other outpatient mental health services. Clubhouses provide peer-run programs using a Recovery, Wellness, and Resilience model in a stigma free environment for adult members living with a mental illness or substance use challenge. There are ten (10) clubhouses located throughout the county that are dedicated to enhancing and supporting recovery. The main objectives of Clubhouses are to assist members in making their own choices, providing peer support, and reintegrating into the community as contributing members, thereby achieving a fulfilling life in alignment with their personal recovery goals. Clubhouses are operated by the members through peer-elected governing boards. Clubhouses provide a variety of supports such as offering warming and cooling services, providing community Narcan Distribution, providing showers and laundry including all hygiene items, hosting on site mobile wellness units such as dental, HIV testing and medical support and allowing for the receipt of mail. These supports offered with a low barrier for entry allows for increased engagement and supports in which trust can be established and further system linkage and navigation can occur.

WET strategies to address and reduce disparities in service and access include the following programs:

- DBH has in place a Peer and Family Advocate (PFA) workforce support initiative. PFAs are behavioral health clients or family members of behavioral health clients who provide crisis response services, peer counseling, linkages to services, and support for clients of DBH services. The PFA workforce support initiative supports 55 full time PFA positions throughout DBH. This added diversity builds upon the lived experience and adds a greater dimension to service provision. Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification (see Criterion 6). The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles.
- DBH works continually with the Human Resources Department to continually recruit bilingual and bicultural staff.
- DBH has an Employee Educational Internship program to support current DBH staff in pursuing their Master of Social Work (MSW) or Marriage and Family Therapy (MFT) degrees, by allowing them to intern for up to 20 hours per week at DBH as part of their degree requirements. The program was created to support the WET initiative of building a more skilled workforce by "growing our own" qualified staff to fulfill the identified clinical shortages within the department. Since its implementation, the program has increased in popularity, and in April 2015, was expanded by adding the Alcohol and Drug Counselor (AOD) and Bachelor of Social Work (BSW) additional intern career path options. In December of 2020, the program was expanded again to include Licensed Registered Nursing, Bachelor of Science in Nursing, Master of Science in Nursing, Licensed Vocational Nursing, and Nurse Practitioner as additional intern career path options.
- DBH continues to have an internship program in place to train the future behavioral health workforce in treating clients with severe mental illness. The internship program also works to address the shortage of behavioral health providers. Currently, the Internship Program trains students who are enrolled in the following bachelor and graduate programs: Social Work, Marriage and Family Therapy (MFT), and Psychology. Depending on their discipline, interns participate in the Internship Program for 12 to 18 months. During that time, they learn to provide clinical services in a public community behavioral health setting. DBH is committed to hiring applicants that were previously interns (see Criterion 6). The Internship and Residency Program will expand in 2025 to include internship opportunities for individuals working toward their AOD certification.
- DBH has Medical Education Programs that provide medical professionals the opportunity for exposure to, and training in, the public mental health system (see Criterion 6).
- DBH has a dedicated Volunteer Services Coordinator who conducts focused outreach to high schools, adult education, community colleges, universities, and Regional Occupation Programs (ROP's) to inform audiences on behavioral health career opportunities and offer volunteer opportunities to individuals interested in behavioral health careers (see Criterion 6).
- DBH has in place an Employee Scholarship Program (ESP) to assist current DBH and contract agency employees in furthering their education to be able to pursue higher level careers in the public mental health system. This is also an incentive to recruit and retain employees within the public mental health system.
- DBH has in place a License Exam Preparation Program (LEPP) for clinicians seeking licensure. The process to get licensure has numerous parts and the license preparation

allows for staff to spend the required time on exam preparation to improve their chances of successful examination completion.

- DBH has a Department Diversity Committee (DDC) for employees. The mission of the DDC is to promote equity, diversity and inclusion throughout the department's workforce. The DDC helps guide the development and maintenance of policies and programs that guarantee the successful recruitment, employment, training, promotion and retention of a diverse, skilled workforce to serve San Bernardino County residents. DDC solicits diverse input from all levels of DBH staff and provides recommendations to the executive team on ways to enhance our system of care through diversity. The DDC is supported and managed by the Office of Equity and Inclusion.

PEI strategies to address and reduce disparities in service and access include the following programs:

- Stigma and Discrimination Reduction: The Native American Resource Center functions as a one-stop center offering several prevention and early intervention services for the Native American community members of all ages. The center provides services that incorporate traditional and strength-based Native American practices. Services include outreach and education, family support, parenting education, youth empowerment, healthy choice prevention activities, talking circles, drumming circles, employment development, and education assistance. All services and supports are provided to the community in a culturally relevant context.
- The Promotores de Salud/Community Health Workers (PdS/CHW) program is categorized as a State Outreach for Increasing Recognition of Early Signs of Mental Illness. The PdS/CHW program is designed to increase awareness of community-based prevention and mental health services in culturally diverse communities. The program promotes mental health awareness, education, and available resources for members of culturally-specific populations throughout the county. Services are designed to increase awareness of and access to the behavioral health system of care. The program targets five specific cultural populations identified by community stakeholders as having the highest need: Latinx/Hispanic, African American/Black, Asian/Pacific Islander, LGBTQ, and Native American.Access and Linkage to Treatment: The Child and Youth Connection (CYC) program address prevention and early intervention in another high disparity population, which are children. The program focuses on PEI for foster children, who are disproportionately of color.
- Prevention: The Preschool PEI Program provides prevention services to children ages two through five, their parents or caregivers, and teachers.
- Prevention: The Resilience Promotion in African American Children (RPiAAC) program provides prevention and early intervention services to African American children/youth (ages 5-18) and their families. Resilience Promotion in African American Children incorporates African American values, beliefs, and traditions into educational mental health programs. This program promotes resilience in African American children in order to reduce the development of mental health and/or substance use disorders. Outreach and education initiatives are implemented across diverse student populations, including African American students, to promote awareness of the significance of mental health and wellness for all students within the school community. The program includes curriculum-based education, cultural awareness activities, conflict resolution training, educational workshops, weekly interventions, career-related presentations, parent support/education, individual and family therapy sessions, and linkage to additional resources.

- Prevention: The Lift Program is designed to promote healthy outcomes for at risk mothers and their infants. Nurses provide education and services in participants' homes to promote the physical and emotional care of children by their mothers, family members, and caretakers. Families are linked with needed physical and mental health services. This program is administered by the San Bernardino County Preschool Services Department.
- Prevention: The Coalition Against Sexual Exploitation (CASE) is a partnership of public and private entities who have joined together to develop resources in the county to educate, prevent, intervene, and treat victims of commercial sexual exploitation.
- Prevention: The Older Adult Community Services program is a prevention program designed to promote a healthy aging process for older adults (ages 60+).
- Early Intervention: Family Resource Centers provide prevention and early intervention for family systems with regards to all of the PEI target populations.
- Early Intervention: The Military Services and Family Support program addresses all PEI target populations with a focus on military families, who also have a higher disparity in needs and access to services.
- Early Intervention: The Community Wholeness and Enrichment (CWE) program focuses on early intervention for TAY and adult populations and addresses all of the other PEI components
- Early-Intervention: The Student Assistance Program (SAP) minimizes barriers to learning and supports academic success for at risk students/families. This focuses on disparity reduction with the high-risk population for school failure, which heavily impacts African American and Latino children at greater proportions.
- Early Intervention: The Improving Detection and Early Access (IDEA) identifies individuals with a clinical high risk (CHR) for developing psychosis and intervene as soon as possible during the first episodes of psychosis. Individuals presenting with early psychosis usually present with multiple problems such as suicidal ideation, aggressive behavior, legal difficulties, school challenges, and are often diverted to other systems that do not include mental health supports. The program will focus services on Transitional Aged Youth populations.
- Substance Use Prevention and Pathways to Outreach and Treatment (SUPPOrT) effective FY 2024/2025, is a program categorized as an Outreach for Increasing the Recognition of Early Signs of Mental Illness. It encompasses a multidisciplinary mix of partners working across sectors that include county agencies, community agencies and institutions, professional partners, and residents working together to educate one another and support and develop strategies to combat the opioid crisis. The goal is to continue to work collaboratively across partnerships to reduce opioid use and opioid-related deaths in San Bernardino County.
- Prevention: Office of Suicide Prevention: Provide a broad audience with resources and strategies to prevent suicide in our community. The office will enhance life skills and resilience, promote social connectedness and support, increase help seeking, Identify and assist persons at risk, ensure access to effective mental health and suicide care and treatment, respond effectively to individuals in crisis, support safe care transitions and create organized linkages, provide for immediate and long term postvention, and reduce access to lethal means and promote means safety.

3-IV: Additional Strategies/Objectives/Actions/Timelines and Lessons Learned.

3-IV-A: List any new strategies not included in Medi-Cal, CSS, WET, and PEI.

Note: New strategies must be related to the analysis completed in Criterion 2.

No new strategies in FY 2024/2025.

3-IV-A-I: Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

To view the full results of CSS, WET and PEI strategies that are working well and lessons learned to address and reduce disparities in service and access listed in 3-III-A, please view the MHSA FY 2025/2026 Annual Plan Update approved in May of 2025 by the County Board of Supervisors. 10216 - Item #38 Executed BAI (sbcounty.gov)MHSA-Plan-Annual-Update-FY25-26.

CSS: What is working well and lessons learned include: One Stop TAY Centers

One Stop TAY Centers are an example of a CSS FSP program that is working to reduce disparities and assist youth as they transition into adulthood. DBH uses the San Bernardino Adult Needs and Strengths Assessment (ANSA-SB) tool to identify and track participant's clinical progress.

The data below represents the percentage of youth who presented with a significant issue on an item within the Life Domain Functioning and had this issue improve by their completion of the program for the period July 1, 2021 through June 30, 2025.

Note: Due to the length of time most TAY consumers spend in the program, data was pulled for July 1, 2021 through June 30, 2025 (the completed fiscal years of the current contract) to showcase the level of progression that TAY members experience.

- 59% (182/306) of youth who presented a significant issue in Family Relationships had this issue improve.
- 67% (216/323) of youth who presented a significant issue in Social Functioning had this issue improve.
- 66% (170/259) of youth who presented a significant issue in Recreational had this issue improve.
- 32% (12/37) of youth who presented a significant issue in Physical/Medical had this issue improve.
- 65% (141/217) of youth who presented a significant issue in Sleep had this issue improve.
- 61% (140/230) of youth who presented a significant issue in Living Skills had this issue improve.
- 64% (94/146) of youth who presented a significant issue in Residential Stability had this issue improve.
- 67% (159/237) of youth who presented a significant issue in Self-Care had this issue improve.

- 63% (22/35) of youth who presented a significant issue in Medication Compliance had this issue improve.
- 54% (132/243) of youth who presented a significant issue in Decision-Making/ Judgement had this issue improve.
- 66% (39/59) of youth who presented a significant issue in Involvement in Recovery/Motivation for Treatment had this issue improve.
- 58% (14/24) of youth who presented a significant issue in Parenting Roles had this issue improve.
- 60% (110/183) of youth who presented a significant issue in Intimate Relationships had this issue improve.
- 66% (112/169) of youth who presented a significant issue in Educational Attainment had this issue improve.
- 53% (135/253) of youth who had no identified strength or needed significant strength building efforts with Family/Family Strengths/Support improved.
- 60% (184/309) of youth who had no identified strength or needed significant strength building efforts with Interpersonal/Social Connectedness improved.
- 66% (135/204) of youth who had no identified strength or needed significant strength building efforts with Optimism improved.
- 59% (78/132) of youth who had no identified strength or needed significant strength building efforts with Educational Setting improved.
- 50% (102/203) of youth who had no identified strength or needed significant strength building efforts with Vocational improved.
- 55% (155/281) of youth who had no identified strength or needed significant strength building efforts with Community Connection improved.
- 55% (130/237) of youth who had no identified strength or needed significant strength building efforts with Natural Supports improved.
- 64% (107/168) of youth who had no identified strength or needed significant strength building efforts with Resilience improved.
- 59% (94/158) of youth who had no identified strength or needed significant strength building efforts with Resourcefulness improved.

The data below represents the Percentage of youth who presented with a significant issue on an item within the Strength's domain and had this issue improve by their completion of the program for the period July 1, 2021 through June 30, 2025.

- 61% (140/230) of youth who presented a significant issue in Living Skills had this issue improve.
- 64% (94/146) of youth who presented a significant issue in Residential Stability had this issue improve.

CSS: What is working well and lessons learned include: Age Wise Program

The Age Wise Program is another example of an FSP program that is working to reduce disparities for older adults. DBH uses the state Data Collection and Reporting (DCR) system to collect Full-Service Partnership data.

The following table represents the measured Age Wise outcome domains and the percentage of key outcome results for consumers in FY 2024/2025:

Table 7-AgeWise Outcome Domains in Percentages

Outcome Domain	Percentage
Maintained low or reduced risk of subjective suffering as determined by the DCR	61%
Maintained safe and stable housing	97%
Consumers linked to a Primary Care Physician	100%
Diverted from hospitalizations related to a behavioral health diagnosis	100%
Clients are stable and are able to seek outside assistance to locate their own resources	71%
Reduction in disparities in racial and ethnic populations	• 44% reported being Caucasian • 32% reported being Latino • 17% reported being African American/Black • 1% reported being Asian • 2% reported being Native American • 33% reported being Other

WET: What is working well and lessons learned include: Peer and Family Advocate (PFA) Workforce Support Initiative program:

There has been a significant increase in PFAs hired in DBH over the years. This is largely due to increasing knowledge and evidence of the benefits resulting from the inclusion of PFAs in many DBH programs and the positive outcomes it has yielded on the clients served by these programs.

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification, if desired. The table below shows the number of DBH PFAs promoted since FY 2013/14. In FY 2024/2025, there are a total of 41 PFA's on staff.

Table 8: PFA's Promoted

FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
4	3	4	3	5	6	11	2	4	5	5	4

The passage of SB 803 Mental Health Services: Peer Support Specialist Certification Program Act of 2020 brings more opportunity for our county to increase our peer workforce. A new program under MHSA has been developed and approved by stakeholders to support local implementation "Peer Provider Workforce Support".

Creating a division titled Peer Programs which specifically focuses on targeted enhancements of the PFA workforce has allowed for additional onboarding, supervisory training and elevation of the position within programs. This allows for more programs to benefit from the increased outcomes that peer providers produce when involved in engaging and supporting unserved populations. This unit also monitors the certification and ongoing renewal of Medi-Cal Peer Support Certification for all peer providers, identifies and develops system supports, and works with the PFAs and their supervisors to monitor and improve ongoing implementation efforts. PFA Engagement meetings, Supervisor Collaboration Meetings, and ongoing trainings to meet the continuing education requirements of certification are currently in the design and implementation phase. Despite retention challenges there are currently 23 Peer and Family Advocates that have an active certification representing over 50% of the current workforce.

This unit will also coordinate DBH efforts to reduce the vacancy rate of this position and has already implemented a continuous recruitment strategy, standardized classification, and is actively engaged in communication with Human Resources to implement other equity measures. The classification has grown from 36 filled positions in FY 2023/24 to 41 filled positions in FY 2024/25. There is a total of 55 positions in this classification.

PEI: What is working well and lessons learned include: Community Health Workers/ Promotores de Salud (CHW/PdS)

In FY 2024/25, collectively all CHW/PdS providers reached 104,134 (many participants declined to answer race/ethnicity questions) unduplicated participants from identified unserved and underserved county populations.

African American	280
Asian/Pacific Islander (API)	353
Native American (NA)	111
Latino/x	12,371
LGBTQ	248

CHW/PdS providers that have collaborated with other community-based organizations and schools have educated them on the importance of collecting and sharing demographic data. There still is a large amount of stigma within the API, NA, and LGBTQ communities, and trust with providing demographic information.

For full program information and outcomes see Plans and Reports posted on the DBH MHSA program website page Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov),

3-V: Planning and Monitoring of Identified Strategies/Objectives/Actions/Timelines to Reduce Mental Health Disparities

(Criterion 3, Section I through IV requires counties to identify strategies, objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

3-V-A: List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.). See the next page for a graphic list of strategies, objectives and timelines related to the planning and reduction of our mental health disparities.

Table 9A

Objective:	Reduce Disparities in Access for the following Medi-Cal Populations: Latino Asian/Pacific Islander and African American
Time Frame:	Ongoing
Strategies:	Partner with CBOs in the development and implementation of culturally specific outreach and education materials. Train members of cultural communities to train members of community on mental health topics and resources
Actions:	Release Request for Proposals to solicit qualified vendors for the delivery of Community Health Worker/Promotores de Salud (CHW/PdS) services for Latino, African American, Native American, LGBTQ and Asian Pacific Islander populations. Obtain Board of Supervisors Approval for selected vendors. Recruit providers (/CHW/PdS) Develop curriculum and train cultural brokers.
Current Status:	Completed: Contracts in place for July 1, 2022 through June 30, 2026. See FY 2024/2025 Annual Update for (CHW/PdS) information. MHSA-Plan-Annual-Update-FY25-26.

Table 9B

Objective:	Reduce Disparities in Access for the following Medi-Cal Populations: Latino and African American
Time Frame:	Ongoing
Strategies:	Partner with culturally specific organizations to support cultural events and outreach.
Actions:	Collaboration with the African American community in the 2nd Annual Black Mental Health Awareness Conference: Just Breathe. Collaboration with Latino community to celebrate Emotional Wellness in Latino in the Mexican Consulate Annual Resource Fair.
Current Status:	Completed and ongoing. FY 2024/2025 the African American subcommittee hosted 10 hybrid meetings with 266 participants in the fiscal year. The Latino subcommittee hosted 9 meetings hybrid with 140 participants throughout the Fisal Year.

Table 9C

Objective:	Reduce Disparities in Access for the following CSS Populations: Latino, African American, Criminal Justice and Older Adults
Time Frame:	Ongoing
Strategies:	Expand Full-Service Partnerships (FSP) to additional populations
Actions:	Develop RFP to expand Regional FSP services. Implement new contract with CBO to expand FSP services to diverse populations living in homelessness; conduct bi-weekly support and technical assistance meeting with new contractor. Provide mobile services and coordination of transportation support for older adult population. Expand FSP service to additional justice involved populations.
Current Status:	Completed: DBH has 9 FSP programs in place including Adult Forensic Services FSP and Age Wise FSP. See MHSA Annual Plan Update for FY 2025-26 at 10216 - Item #38 Executed BAI (sbcounty.gov) MHSA-Plan-Annual-Update-FY25-26.

Table 9D

Objective:	Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates
Time Frame:	Ongoing
Strategies:	Peer and Family Workforce Support Initiative
Actions:	Continuous recruitment for vacant Peer and Family Member positions. Inclusion of the Peer and Family Member position is a requirement in applicable MHSA funded contracts with requirements to support Medi-Cal Peer Support Specialist Certification where appropriate. Continuation of Peer and Family Member support across department through creation of the Peer Programs division, position specific onboarding and supervisory supports. Support continuing education and certification for peers to bill Medi-Cal under Senate Bill (SB)803 Medi-Cal Peer Support Specialist Certification Program.
Current Status:	Recruitment has been changed to ongoing allowing for continuous recruitment and capturing of potential staff recently entering the workforce as a result of Medi-Cal peer specialist certification efforts. Director approved additional onboarding support 90 days after employment for enhanced fidelity to peer provider work. MHSA funded contracts include PFA positions as appropriate and encourage Medi-Cal Peer Specialist certification support where appropriate. Bilingual staff desired qualification on job recruitment. In FY 2024/2025, 41 of 55 positions were filled in DBH. As of June 2025, 23 currently employed Peer and Family Advocates have received certification with 4 additional former certified Peer and Family Advocates promoted.

Table 9E

Objective:	Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates
Time Frame:	Ongoing
Strategies:	Build a Culturally Competent Workforce
Actions:	Offer trainings to staff and contracted provider staff on Latino and Peer and Consumer Culture. Coordination with the Office of Equity and Inclusion
Current Status:	WET provided 292 trainings in FY 2024/2025 OEI Provided 32 trainings in FY 2024/2025

Table 9F

Objective:	Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates
Time Frame:	Ongoing
Strategies:	Outreach to high school, adult education, community college and Regional Occupational Program (ROP) to address/educate a future diverse workforce in Behavioral Health
Actions:	Participate in school-based outreach events
Current Status:	Completed: WET coordinator visited 31 schools and reached 7,173 individuals in FY 2024/2025

Table 9G

Objective:	Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates
Time Frame:	Ongoing
Strategies:	Expand Internship program
Actions:	Provide quality internship opportunities for interns across three disciplines (BSW, MFT, MSW and Psychology).
Current Status:	Completed: 52 interns participated in DBH's Internship Residency Program in FY 2024/2025

Table 9H

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Comprehensive Treatment Services/Student Assistance Program (SAP)
Actions:	Release RFP to solicit vendors for comprehensive service for school-aged children, using a blended funding structure of PEI and Medi-Cal. Obtain BOS approval for contracted providers to extend providing services in FY 2024/2025. Train providers in contractual requirements. Support early implementation efforts through technical assistance.
Current Status:	Completed. All contracts are in place and partnerships remain ongoing through June 30, 2026. Collaborated with San Bernardino County Superintendent of Schools in a multi-day Wellness Conference. Provided training at the Wellness Conference to over 900 attendees who work closely with children and youth. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) as well as the MHSA-Plan-Annual-Update-FY25-26 for program updates.

Table 19I

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Resilience Promotion in African American Children Program (RPiAAC)
Actions	Release RFP to solicit vendors for the RPiAAC program. Obtain BOS approval for contracted providers to extend providing services in FY 2024/2025. Train providers in contractual requirements. Support early implementation efforts through technical assistance.
Current Status	Completed. All contracts are in place and partnerships remain ongoing through June 2026. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) as well as the MHSA Annual Plan Update for FY 2025-26 for program updates.

Table 9J

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Preschool Prevention Programs: Preschool PEI Program and Lift Program
Actions	Establish internal MOU with Preschool Department Obtain BOS approval for contracted providers to begin providing services in FY 2017/2018. Train Preschool Department in contractual requirements. Support early implementation efforts through technical assistance.
Current Status	Program sunset June 30, 2025. New Program, Building Blocks for Success, became effective date: July 1, 2025 – June 30, 2026 . See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) as well as the MHSA-Plan-Annual-Update-FY25-26

Table 9K

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Family Resource Center
Actions	Release RFP to solicit vendors for comprehensive service. Obtain BOS approval for contracted providers to begin providing services in FY 2023/2024. Support early implementation efforts through technical assistance.
Current Status	Completed: All contracts are in place and partnerships remain ongoing through June 2026. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) for program updates.

Table 9L

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Native American Resource Center
Actions	Continue partnership with culturally specific vendor in the delivery of PEI services. Support culturally specific outreach events. Collaborate through CCAC Native American Subcommittee.
Current Status	Completed: All contracts are in place and partnerships remain ongoing through June 2026. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) for program updates. FY 2024/2025 Native Awareness Subcommittee hosted 10 meetings in person and hybrid with 240 participants throughout the Fisal Year.

Table 9M

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Community Health Worker/Promotores de Salud (CHW/PdS)
Actions	Release Request for Proposals to solicit qualified vendors for the delivery of CHW/PdS services for Latino, African American, Native American, LGBTQ and Asian Pacific Islander populations Obtain BOS approval for selected vendors. Recruit CHW/PdS. Develop curriculum and train cultural brokers.
Current Status	Completed: Contracts in place for July 1, 2022 through June 30, 2026. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) for program updates.

Table 9N

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Military Service and Family Support Program
Actions	Release RFP to procure culturally specific PEI services. BOS approval for contracted provider agencies to provide services. Coordinate training and support for working the Military culture.
Current Status	Completed: All contracts are in place and partnerships remain ongoing through June 2026. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) for program updates.

Table 9O

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	Community Wholeness and Enrichment Program
Actions	Extend current services with CBOs. Development of RFP to solicit ongoing provision of early intervention services.
Current Status	Completed: All contracts are in place and partnerships remain ongoing through June 2026. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) for program updates.

Table 9P

Objective:	Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare
Time Frame:	Ongoing
Strategies:	LIFT Program
Actions	Continued partnership with the Preschool Services Department Early Head Start program.
Current Status	Program sunset June 30, 2025. New Program, Building Blocks for Success, became effective date: July 1, 2025 – June 30, 2026. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) for program updates.

3-V-B: Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

The Research and Evaluation office at DBH produces regular reports on the population served by the Mental Health Plan (MHP) and Substance Use Disorder (SUD) programs using data collected through the department's electronic health record myAvatar. PEI and other MHSA (Innovation, WET, CSS) program data not captured through myAvatar is compiled and monitored regularly through monthly forms and biannual reports. This information allows program and the Office of Equity and Inclusion (OEI) staff to monitor the effectiveness of programs to reach unserved, underserved and inappropriately served cultural populations. OEI provides technical assistance to programs that are having difficulty in reaching their targeted populations.

Not only are strategies for reducing disparities monitored and evaluated internally, but all programs also provide regular presentations on their services to the public through Behavioral Health Commission, District Advisory Committees, Cultural Competency Advisory Committee and Subcommittees, Substance Abuse Provider Network and Community Policy Action Committee meetings, as well as at other forums as requested as described in Criterion 1. The community provides feedback on programs and identifies gaps in services.

All MHSA programs are analyzed on an annual basis by county staff to assess program outcomes. MHSA staff analyze all data collected by programs to assess the number of unduplicated participants served, demographics of participants, and outcomes data. In annual reports, MHSA staff share the impact of funded programs, and report progress towards the reduction of disparities among underserved and inappropriately served populations.

The Cultural Competency Advisory Committee (CCAC) and fourteen (14) subcommittees serve as a mechanism to monitor the effects of DBH's efforts to reduce disparities. CCAC is a committee of community-based providers, organizations, partner agencies, clients, family members, faith-based organizations/individuals, representatives from various DBH departments, primary care providers and other interested parties who advocate for the development, implementation and evaluation of high quality, culturally/linguistically attuned, behavioral health services capable of meeting the diverse needs of all cultural groups in San Bernardino County. CCAC members and subcommittees are regularly asked to provide feedback to OEI staff and the Equity and Cultural Competency Officer (ECCO) on how to improve the DBH system of care. Such feedback is shared by the ECCO with the Executive Team at DBH and appropriate program staff.
Finally, the ECCO is part of the department's Quality Management Action Committee (QMAC) and leads the department's Quality Improvement Performance Plan (QIPP) section on monitoring the behavioral health needs in specific cultural and ethnic groups. The section workgroup monitors the departments outreach and engagement efforts to Mental Health and Substance Use Disorder target populations, language services capacity and staff cultural competency training completions and needs. DBH's QIPP can be located on the DBH website homepage https://wp.sbcounty.gov/dbh/.

3-V-C: Identify county technical assistance needs.

No technical assistance required.

CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM
CLAS Standard: 13

4-I: The County has a Cultural Competence Committee, or other Group that Addresses Cultural Issues and has Participation from Cultural Groups, that is reflective of the Community.

4-I-A: Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).

The Cultural Competency Advisory Committee (CCAC) is a committee of community-based providers, organizations, partner agencies, clients, family members, faith-based organizations/individuals, representatives from various DBH departments, primary care providers and other interested parties who advocate for the development, implementation and evaluation of high quality, culturally/linguistically attuned, behavioral health services capable of meeting the diverse needs of all cultural groups in San Bernardino County.

The CCAC meets monthly and has established direct channels of communication with the staff of the Office of Equity and Inclusion (OEI) and the Equity and Cultural Competency Officer (ECCO). The CCAC and subcommittees are community-led and chaired by members of the community. The CCAC interacts closely and advises the ECCO on pertinent information and research data regarding the special needs of the target populations in the community. Likewise, information also flows from the ECCO and OEI to the CCAC and the diverse communities the membership represents. The philosophy of the CCAC includes the belief that persons of all cultural backgrounds have the right to receive quality behavioral health services, regardless of age, creed, gender identity, sexual orientation, ethnicity, socio-economic status, disability or nationality.

The objectives of the CCAC are:

- Promoting equitable distribution of behavioral health services utilizing multi-lingual, multi-cultural staff.
- Promoting equal access to behavioral health services.
- Advocating the equitable and efficient use of resources in the behavioral health system.
- Promoting community inclusion and input.
- Promoting community awareness about behavioral health issues.
- Advancing cultural attunement through participation in joint efforts to improve the policies and effectiveness of behavioral health services for all cultural groups.
- Promoting equitable research and evaluation of behavioral health needs and interventions and promising culturally responsive practices with culturally diverse communities.
- To work towards cultural attunement and cultural competency as defined as “a set of congruent practice, skills, attitudes, policies and structures which come together in a system, agency or among professionals to work effectively with diverse populations.”(Cross, et al, 1989, cited in DHCS Information Notice 03-04)

The following are the roles and responsibilities of the members of the DBH Cultural Competency Advisory Committee per Title 9, Chap. 11, Article 4 Section 1810.410 (b):

- Review policies, mission, and program statements to ensure Cultural Competency principles are included,
- Analyze Department services programs, related to county/state demographics, trends, research findings regarding access, retention, and treatment of specific cultural groups by age, gender, language, poverty, and other criteria,
- Hold focus groups to share cultural information, support, resources and receive feedback from the community,
- Review and recommend ways to enhance client/family input,
- Develop opportunities to increase community partnerships and collaboration,
- Review and update DBH's capacity and capability to provide competent cultural and linguistic services,
- Review and update the Cultural Competency Plan annually for submission to the California Department of Health Care Services (DHCS).

The CCAC has developed by-laws (Attachment A6) that address values, objectives, subcommittee structure, membership, composition, and commitment. The committee officers include a Chair and Vice Chair, who are elected annually, each on alternating years. The officers are responsible for the initiation of a strategic plan based on the CCAC input and the needs of the community that results in a final CCAC Annual Report to the ECCO s.

The CCAC meets monthly, and subcommittees hold their own monthly meetings addressing more specific disparity issues. Subcommittees report out to the CCAC on their activities at monthly CCAC meetings. One subcommittee is highlighted at each monthly meeting. Chairs are given 15 minutes on the agenda to present on their subcommittee and invite individuals to join and participate in their activities. The CCAC subcommittees maintain a work plan that they review and update annually (Attachment A8). In addition, the CCAC coordinates monthly presentations to attendees on various topics and programs that have been identified by participants (Attachment A9).

Subcommittees under the CCAC:

1. African American Awareness Subcommittee
2. Asian Pacific Islander Awareness Subcommittee
3. Mental Health and Substance Use Awareness Subcommittee
4. Consumer and Family Members Awareness Subcommittee
5. Disabilities Awareness Subcommittee
6. Latino Awareness Subcommittee
7. LGBTQ Awareness Subcommittee
8. Native American Awareness Subcommittee
9. Older Adults Awareness Subcommittee
10. Spirituality Awareness Subcommittee
11. Suicide Prevention Awareness Subcommittee
12. Transitional Aged Youth (TAY) Awareness Subcommittee
13. Veterans Awareness Subcommittee
14. Women’s Awareness Subcommittee

4-I-B: The County shall include the following in the CCPR: Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

The CCAC has developed by-laws that address values, objectives, subcommittee structure, membership, composition and commitment. The officers of the CCAC consist of a Chair and a Vice-Chair, who are elected annually, each on alternating years. The Chair shall not be a DBH employee; however, in the event of unprecedented situations where no other non-DBH CCAC members have applied for or shown interest in becoming the Chair, then a DBH employee, by vote can serve as the Chairperson. The Chair shall appoint a nominating committee to present nominations for the election of new officers at the October monthly meeting.

The by-laws of the CCAC also state under Article VI Section I. Participation and Composition:

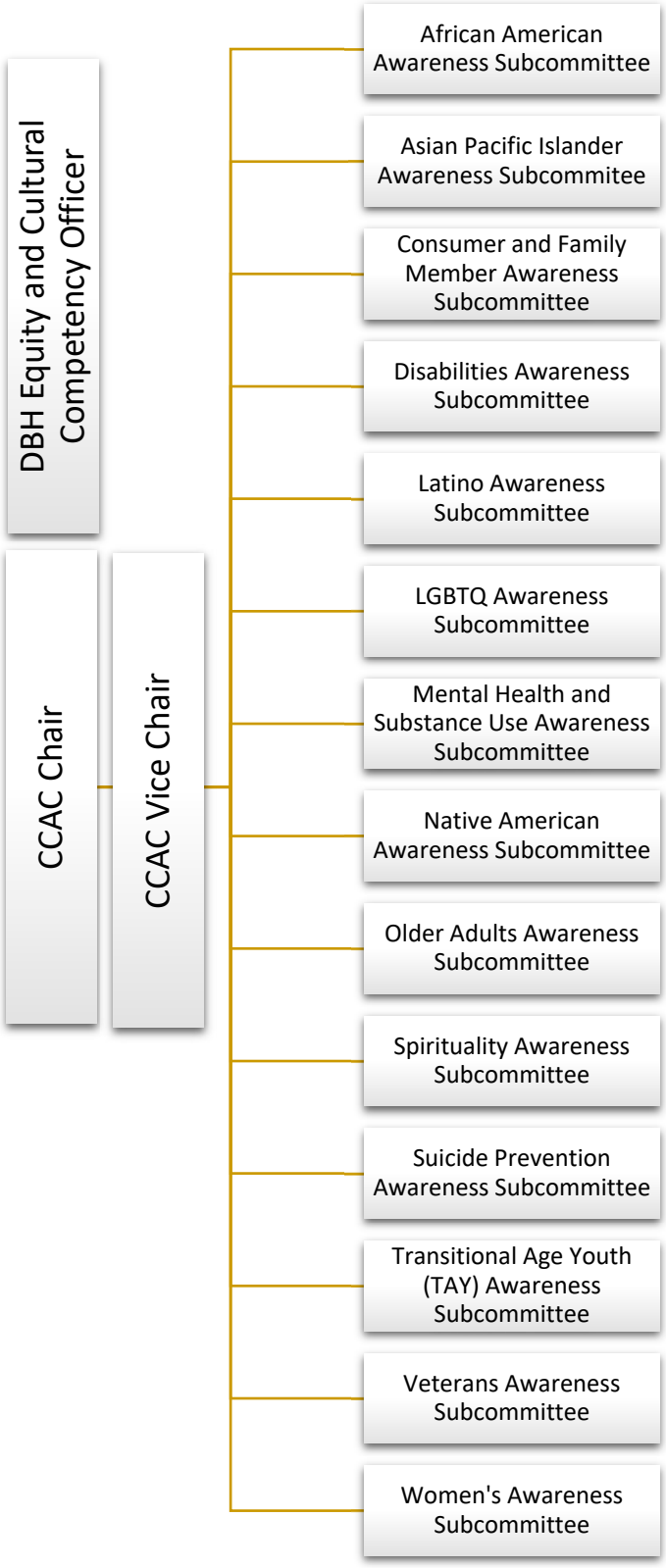
1. Participation will be open-ended; new members can join at any time in the year
2. Participants will include: diversity of community members, consumers, family members, private practice providers, contractors, primary care providers, faith-based organizations/individuals, community-based agencies, representatives from various Department of Behavioral Health programs, elected members, community leaders, and other interested individuals.
3. The Cultural Competency Advisory Committee will be comprised of seventeen (17) active voting members, including one (1) voting member from each subcommittee, the CCAC Chair and Vice Chair and the Equity and Cultural Competency Officer.
4. Staff from the Office of Equity and Inclusion (OEI) will be responsible for the orientation of new members.
5. The Cultural Competency Advisory Committee will put out a mission statement, which in turn will be directed to different agencies outside and within county departments to let them know the importance of attending CCAC.
6. CCAC meetings will also be an appropriate forum to discuss issues or concerns raised by community as they relate to the delivery of behavioral health services, access, equity, outcomes and evaluation designs, and cultural competency.

Additionally, DBH's Cultural Competency Policy CUL1006 assures members of the Cultural Competence Advisory Committee are reflective of the community, including county management level and line staff, clients and family members, providers, community partners, contractors, and other members as necessary.

4-I-C:

Chart 2: CCAC Organizational Chart

Current orgainzational chart of the Cultural Competency Advisory Committee:



4-I-D: Committee membership roster listing member affiliation if any.

CCAC Participant roster, (Attachment A10).

4-II: The Cultural Competence Committee, or Other Group with Responsibility for Cultural Competence, is Integrated within the County Mental Health System.

4-II-A: Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including the following:

- **Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county**
- **Provides reports to Quality Assurance/Quality Improvement Program in the county;**
- **Participates in overall planning and implementation of services at the county;**
- **Reporting requirements including directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;**
- **Participates in and reviews county MHSA planning process;**
- **Participates in and reviews county MHSA stakeholder process;**
- **Participates in and reviews all components of the county's Plan;**
- **Participates in and reviews client developed programs (wellness, recovery, and peer support programs);**
- **Participates in revised CCPR development.**

Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county.

The Office of Equity and Inclusion (OEI) is responsible for the integration of cultural competence throughout the entire DBH system of care. Additionally, the Cultural Competency Advisory Committee (CCAC) as stated previously is a community based advisory group that advises the OEI and the Equity and Cultural Competency Officer (ECCO) of the needs of the community, as well as provides feedback, reviews and participates at various levels of program planning and quality assurance. OEI and CCAC work together to review DBH's services, programs, and cultural competence plan on an ongoing basis. Additionally, the Cultural Competency Policy clearly states the roles and responsibilities of the CCAC, which include the review of DBH services, programs and cultural competency plan.

For evidence of the CCAC's participation in reviews of services, programs, and cultural competence plans with respect to cultural competence issues in the county, see CCAC Annual Report (Attachment A7). The CCAC and subcommittees are active participants in providing feedback and reviewing DBH's Mental Health Services Act (MHSA) programs. See MHSA Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) pages 25 and 26 for list of meetings CCAC and subcommittees participated in.

Provides reports to Quality Assurance/Quality Improvement Program in the county.

The ECCO sits on the Quality Management Advisory Committee (QMAC). The ECCO continues to facilitate the Cultural Competency: Quality Improvement Workgroup. The workgroup is tasked with monitoring mental health needs in specific cultural and ethnic groups.

Goals of the workgroup included:

A. Maintain and analyze the penetration rates for underserved ethnic/cultural populations, twice a year.
B. Increase the number of DBH providers that complete the DBH required hours of Cultural Competency training. Goal: 80%, staff completion.
C. Provide language services training to all DBH new employees to ensure clients receive services in their preferred language when accessing and receiving services. Goal: 100%.

Activities of the workgroup included:

- Perform analysis of the Specialty Mental Health Penetration Rates, specifically for Asian, Pacific Islander and Latino populations.
- Review PROS and MHSA outreach and engagement demographic data.
- Report to QMAC regarding outreach activities specific to engagement of ethnic and cultural groups.
- Review the following:
    - Beneficiary preferred language and workforce linguistic capacity data.
    - Number of Language Services trainings provided.
    - Bilingual skills training to DBH bilingual staff.
    - Utilization of language services.
    - Mystery shopper and test call reports.
    - Grievances related to language services delivery issues.
    - WET training reports for Cultural Competency trainings provided, by staff unit (Administrative, Management staff).
    - Cultural Competency Training Policy, training hour requirements.
    - NACT for cultural competence training data.
- Develop process to validate completion of staff cultural competence training hours for DBH and contract provider staff.
- Monitor cultural competence plan goals.
- Collaborate with Consumer Evaluation Council Quality Improvement Advisory Workgroup to address access and engagement issues.

Workgroup accomplishments for FY 2024/2025 will be included in the Quality Improvement Performance Plan (QIPP) Evaluation located on the DBH Website: Quality Management – DBH Internet Website (sbcounty.gov)

Participates in overall planning and implementation of services at the county.

The CCAC, ECCO and OEI are actively involved in MHSA's stakeholder engagement community planning process. The CCAC and subcommittees annually invite MHSA staff to provide updates to their meeting participants creating opportunities for community stakeholders to provide input and feedback on the DBH system of care. Additionally, stakeholder Comment Forms are included in every CCAC and Subcommittee meeting for input on program development, implementation,

evaluation, and policy of MHSA funded programs. The values of cultural competence are written throughout the MHSA Plan to provide services that emphasize recovery, wellness, and resiliency.

As a result of the stakeholder planning process OEI has been involved in the development of culturally specific programs for the county through MHSA. Specific programs include Native American Resource Center, Community Health Workers/Promotores de Salud, and Resilience Promotion in African American Children. The programs contained in the Plan are designed to develop a continuum of services in which clients, family members, providers, county agencies (including law enforcement and staff), and faith-based and community-based organizations can work together to systematically improve the public behavioral health system in a culturally and linguistically competent and equitable way.

The Cultural Competence Plan (CCP) is continually used for the development and improvement of outreach efforts and programs for underserved groups. DBH in collaboration with the CCAC continues to coordinate ongoing educational forums to increase mental health and substance use disorder awareness and provide informational materials in preferred languages spoken in specific communities. The CCP helps guide the work of the CCAC.

Reporting requirements including directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director.

The ECCO is a direct report of the Director and an integral piece of the executive management team. As such, the ECCO meets on a weekly basis with the executive team regarding concerns and needs of the community and county staff. The ECCO also has bi-weekly supervision with the Director.

Participates in and reviews county MHSA planning process.

During the months of January and February of 2025, the Mental Health Services Act (MHSA) Stakeholder Engagement Forums for the MHSA Annual Update took place. The Department of Behavioral Health conducted over 30 meetings, both virtual and in person for MHSA Stakeholder Engagement Forums in all the county districts, including at the CPAC, DAC, CCAC and CCAC subcommittees which included a Spanish presentation to the Latino Awareness Subcommittee. The MHSA updates served as an opportunity to discuss any updates made to the plan that reflect on what has transpired over the past year, discuss current services offered by the department, and most importantly gave stakeholders and community members the chance to offer feedback to the department. See MHSA Annual Plan Update for Fiscal Years 2025-26 at Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov) pages 25 and 26 for full list of meetings.

Participates in and reviews county MHSA stakeholder process.

The CCAC is continually invited to review and enhance DBH's stakeholder process and as result each of the subcommittees has held MHSA stakeholder meetings, assisted in the recruitment of community members and venues, and have coordinated community-based facilities for stakeholder/community forums.

Participates in and reviews all components of the county's Plan.

The ECCO and OEI are actively involved in MHSA's stakeholder engaged community planning process. Stakeholder Comment Forms are included in every CCAC and subcommittee meeting for input on program development, implementation, evaluation, and policy of MHSA funded programs. The values of cultural and linguistic competence are written throughout the MHSA Plan to provide services that emphasize recovery, wellness, and resiliency. OEI continues to ensure DBH meets the priority needs identified by local diverse community stakeholders, and key community and priority population needs outlined in the Mental Health Services Act (MHSA). The ECCO and OEI are responsible for presenting all components of the county's MHSA plan, Cultural Competency Plan (CCP) and Quality Improvement Performance Plan to the CCAC and subcommittees for review and comment.

Participates in and reviews client developed programs (wellness, recovery, and peer support programs).

The CCAC, and specifically the Consumer and Family Members Awareness Subcommittee, participates in the review of client-developed programs such as our Clubhouse program (described further in Criterion 8). To ensure accessibility and broad client participation, the subcommittee conducts meetings on a rotating basis at various Clubhouse locations and virtually. Members of this subcommittee are vocal about issues in service delivery and have direct access to Clubhouse staff and/or the program manager who regularly attends the meeting to share their concerns.

Participates in Revised CCPR Development.

It is a primary function of the ECCO and OEI to update the CCP. This includes engaging all levels of leadership from across DBH to participate in the process. This also includes regular communication with and buy-in from the CCAC and subcommittees in the development of the plan.

4-II-C: Annual Report of the Cultural Competence Committee's Activities including:

- **Detailed discussion of the goals and objectives of the committee;**
  - **Were the goals and objectives met?**
  - **If yes, explain why the county considers them successful.**
  - **If no, what are the next steps?**
- **Reviews and recommendations to county programs and services;**
- **Goals of cultural competence plans;**
- **Human resources report;**
- **County organizational assessment;**
- **Training plans; and**
- **Other county activities, as necessary.**

Attached is the CCAC Work Plan for FY 2024/2025 (Attachment A8). Goals and objectives are ongoing and completed by Fiscal Year. Work plans are reviewed and updated in January of every calendar year or as requested by the subcommittee members. The CCAC Annual Report for 2025 provides a detailed account of accomplishments for the year (Attachment A7).

Reviews and recommendations to county programs and services:

The CCAC and subcommittees review and make recommendations to department's programs and services annually through MHSA annual update stakeholder meetings or as requested by DBH and its partners.

Goals of Cultural Competence Plans:

The following are the goals and requirements of the CCP:

- Commitment to Cultural Competence
- Updated assessment of service needs
- Strategies and efforts for reducing racial, ethnic, cultural and linguistic mental health disparities
- Client/Family/Family member/Community Committee: Integration of the Committee within the county mental health System
- Culturally competent training activities
- County's commitment to growing a multicultural workforce: Hiring and retaining culturally and linguistically competent staff
- Language capacity
- Adaptation of services

No updates or changes to the cultural competency plan goals have been made.

Human Resource Report:

No report for FY 2024/2025 was requested by the CCAC.

County Organizational Assessment:

In FY 2024/2025, the CCAC did not conduct a county organizational assessment.

Training plans:

Training plans are developed in collaboration with the department's Workforce Education and Training (WET) program.

CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES
CLAS Standard: 4

5-I: The County System shall require all Staff and Stakeholders to receive Annual Cultural Competence Training.

5-I-A: The County shall develop a three-year training plan for required cultural competence training that includes the following:

- **The projected number of staff who needs the required cultural competence training. This number should be unduplicated;**
- **Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period 3.**
- **How cultural competence has been embedded into all trainings.**

DBH has a policy in place, Cultural Competency Training Policy: CUL1014, that requires that all DBH staff and contract provider staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. The policy indicates that staff who do not have direct contact providing services to clients shall complete a minimum of two (2) hours of cultural competency training, and direct service clinical and support staff shall complete a minimum of four (4) hours of cultural competency training each calendar year. Certain cultural competency trainings are mandated either as an incorporated part of New Employee Orientation (NEO) or as a requirement by the respective Deputy Director, Manager, or Supervisor to ensure that staff are most effectively serving the respective populations that the program reaches.

DBH staff and contracted provider staff have access to live and web-based trainings to meet cultural competency training requirements. In FY 2024/2025, OEI staff provided 39 live virtual trainings to 598 DBH staff, contract provider staff and community stakeholders (Attachment A11). DBH's online training system Relias offers 58 courses that qualify for Cultural Competency hours. Additionally, staff who attend community-based trainings and/or out of county trainings can submit a request to OEI to have the training they attended reviewed and qualified to meet DBH cultural competency training hour requirements.

DBH staff compliance with training is monitored annually and verified by staff supervisors during annual work performance evaluation. Statistics gathered through DBH's online training system Relias are also available to show the number of staff who completed cultural competency training requirements in Relias. In FY 2024/2025, Relias reported 7,516 cultural competency training hours granted to DBH and contract provider staff. Of the hours granted to DBH staff, 30% were granted to DBH licensed and pre-licensed Clinical Therapists.

For contractor's compliance with cultural competence, contracted provider's staff are verified during program reviews and site visits by DBH contract monitoring staff. In FY 2025/2026, the Office of Equity and Inclusion (OEI) and the Cultural Competency Quality Improvement Workgroup will continue to review Relias training reports and identify other tools/reports to monitor completion of cultural competency trainings by DBH and contract provider staff. This was not accomplished in FY 2024/2025 due to staffing shortages in OEI.

OEI and WET staff communicate and meet as needed to ensure cultural competency is embedded into all trainings throughout the department by reviewing trainings submitted for content that addresses cultural competence, diversity, equity, implicit bias, customer service, and cultural considerations with underserved and department target populations. Training content that meets these criteria is reviewed and awarded Cultural Competency hours by the Equity and Cultural Competency Officer (ECCO).

OEI and WET set an annual cultural competency training plan and meet frequently to ensure DBH continues to provide quality, relevant trainings, presentations, and events to increase the awareness of cultural diversity, knowledge of strategies to engage diverse communities in culturally and linguistically appropriate services. Some ongoing training topics include:

- Client Culture
- Language Services

5-II: Annual Cultural Competence Trainings

5-II-A: Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function:

List of live Cultural Competence trainings completed by staff and stakeholders for FY 2024/2025 (Attachment A11).

List of Relias cultural competence trainings completed by staff and contract providers for FY 2024/2025 (See Table 10 below).

5-II-B: The County shall include the following in the CCPR: Annual cultural competence trainings topics shall include, but not be limited to the following:

- **Cultural Formulation**
- **Multicultural Knowledge**
- **Cultural Sensitivity**
- **Cultural Awareness**
- **Social/Cultural Diversity (Diverse groups, LGBTQ, SES Elderly, Disabilities, etc.)**
- **Mental Health Interpreter Training**
- **Training staff in the use of mental health interpreters**
- **Training in the use of Interpreters in the mental health setting**

List of live Cultural Competence trainings completed by staff and stakeholders for FY 2024/2025 (Attachment A11).

The following is the list of trainings that award cultural competence hours available to DBH and contracted provider staff online year-round:

Table 10: Relias Online Trainings Awarding Cultural Competency Hours

Course Name	Credit Hours	Number of Participants
Live Virtual		
Basic Motivational Interviewing 2024	6	59
Behavioral Health Interpreter Training	4	73
Consumer Peer and Family Advocate Movement	2	22
Cultural Competency Advisory Committee Summit 2024	6	36
Differential Diagnosis Made Easy	6	11
Eating Disorders Lecture Series 2025 - Session 1	1.5	68
Eating Disorders Lecture Series 2025 - Session 2	1.5	80
Family-Based Therapy and Eating Disorder Diagnosis & Management	13	128
Introduction to Racial Trauma, Session I	4	36
Introduction to Racial Trauma, Session II	4	34
Language Services Interpretation and Translation Training	1	301
Law & Ethics 2025	6	224
Listen-Empathize-Agree-Partner (LEAP)	4	233
National Day of Prayer for Behavioral Health	2	7
Recovery, Resilience, and Wellness	2	45
Seeking Safety	6	27
Seeking Safety - SUDRS	5.5	44
The Cost of Caring: Indirect Trauma, Workplace Burnout & Chronic Stress for Helping Professionals	6	269
Online Course		
A Multicultural Approach to Recovery-Oriented Practice	1	77
Addressing Behavioral Health Needs of Veterans	2	17
Addressing Substance Use in Military and Veteran Populations	1.5	11
Affirmative Action in the Workplace	0.5	12
An Overview of Solution-Focused Brief Therapy - Retired 7/5/2025	1.25	36
An Overview of Substance Use Disorders	1	40
Approaches to Person-Centered Planning in Behavioral Health	1	48
Building Relationships and Community for People with IDD	0.75	3
Choice Making for People with IDD	0.75	4
Clinical Pathways that Inform Adolescent Substance Use Disorder	1.5	23
Cultural Awareness and Humility	0.5	231
Cultural Competence - Retired 9/7/2024	0.5	52
Customer Service in a Behavioral Health Environment 2240	2	400
Diversity and Disability	0.5	36
Employee Wellness: Emotional Awareness	0.25	10
Ethical and Legal Issues for Behavioral Health Interpreters	0.5	8
Family Assessment and Intervention	1.5	6
Identifying and Addressing Older and Dependent Adult Abuse	1.25	43
Identifying and Responding to Intimate Partner Violence	1.5	18

Interventions for Co-Occurring Disorders: Advanced Practice for Clinicians	1.25	9
Introduction to Cognitive Behavioral Therapy	1.25	26
Introduction to Co-Occurring Disorders - Retired 8/1/2025	1.25	13
Overview of Abuse and Neglect of Individuals with IDD	1	7
Overview of Assertive Community Treatment	1.25	12
Overview of Behavioral Health Issues in Older Adults for Paraprofessionals	1	7
Overview of Family Assessment and Intervention - Retired 7/5/2025	1.75	14
Overview of Family Psychoeducation	1.25	4
Overview of the 12 Step Model	1.5	22
Recovery Principles and Practices in Behavioral Health Treatment - Retired 7/5/2025	1	13
Strategies and Skills for Behavioral Health Interpreters	1	12
Supervision of Peers and Other Lived-Experience Professionals	1	8
Supporting Persons with Serious Mental Illness toward Recovery	1.5	24
The Behavioral Health System of Care: An Overview for Interpreters	1	11
The Illness Management and Recovery Model	1	26
Treating Gambling Disorder	1.25	11
Treating Substance Use Disorders in the LGBTQ Community	1	29
Understanding Psychosocial Rehabilitation and Recovery-Oriented Practice	1	25
Using a Strengths-Based Approach with Children and Youth	1	24
Using a Strengths-Based Approach with Children and Youth for Clinicians - Retired 4/5/2025	1	17
Using Solution-Focused Brief Therapy in Clinical Practice	1.25	3
Wrap: One-on-One	1.25	29

Source: DBH Relias Cultural Competency Course Completions

5-III: Relevance and Effectiveness of all Cultural Competence Trainings.

5-III-A: Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

- **Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;**
- **Results of pre/post-tests (Counties are encouraged to have a pre/posttest for all trainings);**
- **Summary report of evaluations; and**
- **Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.**
- **County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.**

Rationale and need for the trainings; Describe how the training is relevant in addressing identified disparities:

Cultural and Linguistic competency trainings are requested directly to OEI, either by DBH Staff, contract providers, community stakeholder or CCAC and subcommittees. In FY 2024/2025, OEI in collaboration with CCAC delivered a one day summit as requested by CCAC with training on the following topic:

Unity in Resiliency

Each training and/or event is designed to educate and provide awareness to behavioral health providers about the obstacles and cultural norms of the communities we serve. Having this information assists in improving access to care, quality of care and better outcomes for clients and their families.

Results of pre/post-test:

In FY 2024/2025, WET implemented a 4-Month Post-Training Evaluation to test participants' knowledge prior to and after training is received. The post training evaluation was developed to assess the long-term effectiveness of training programs. The primary goals are to measure information retention, evaluate the application of training content, and determine the relevance and benefits of the training to employees' job roles. By gathering feedback from DBH and Contract Agency employees four months after training, WET aims to understand the sustained impact of the training and how well it meets their current job needs. This evaluation provides insights to improve future training sessions, refine materials, and identify if additional resources, follow-up training, or support are needed. Ultimately, ensuring our training programs remain effective and aligned with the evolving needs of our workforce.

Summary report or evaluations:

After a training has been concluded, an evaluation/satisfaction survey is given to all participants, to express their satisfaction with the trainer, overall content, relevance. That information is used to inform and develop/update future trainings. All DBH training evaluations include the following question to ensure cultural competence is addressed in the training.

- Content of the Training: The training addressed cultural issues and issues of diversity.

See Attachment A12 to view evaluation forms from OEI training event(s).

Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings:

In FY 2025/2026, OEI will work with Workforce Education and Training and Research and Evaluation to develop post surveys which captured staff skills learned in trainings.

County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

OEI, in collaboration with Workforce Education and Training and Research and Evaluation will continue its meetings in 2026 to develop post training surveys to capture if staff is utilizing the skills learned 30 or 60 days after they received training.

Sample questions for a post survey may include:

- Are you utilizing the skills/information you gained from the training?
- How are you utilizing the skills/information you gained from the training?
- What are your challenges in utilizing the skills/information you learned in the training?
- Do you need a refresher or additional training in utilizing the skills/information you learned in the training?

5-IV: Counties must have a Process for the Incorporation of Client Culture Training throughout the Mental Health System.

5-IV-A: Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities.

OEI in FY 2024/2025 provided four trainings on Client Culture "Recovery, Resilience, and Wellness (Us + Them = We)" and one "Consumer/Peer and Family Advocate Movement".

"Recovery, Resilience, and Wellness (Us + Them = We)" is focused on educating staff and contract agencies about the culture of people receiving behavioral health services in San Bernardino County. "Recovery, Resilience, and Wellness" helped participants define and understand recovery, resilience and transformation through role play, personal stories, and discussion of the "Medical Model" and "Recovery Model". OEI facilitated this training with participation from Clubhouse and One Stop TAY Center members.

Training dates were held in-person on two separate occasions times.

- May 21, 2025, 1pm to 3pm
- June 12, 2025, 10am to 12pm

Consumer/Peer and Family Advocate Movement provides the history of the consumer movement, the adaptation of consumers into services delivery and the departments implementation and integration of a peer workforce.

This training was held in person on two separate occasions, time, and location:
on May 29, 2025 from 9am-m – 12pm
June 26, 2025 from 3 pm to 5 pm
The training participant evaluations can be found on Attachment A13.

5-IV-B: The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretakers', personal experiences with the following:

- ✓ **Family focused treatment;**
- ✓ **Navigating multiple agency services; and**
- ✓ **Resiliency.**

Family Focused Treatment:

- Race Based Trauma

Navigating Multiple Agency Services:

- Implicit Bias

Resiliency:

- National Day of Prayer
- CCAC Summit
  - Unity in Resiliency
- Recovery, Resilience, and Wellness
- Consumer/Peer and Family Advocate Movement Training

CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

CLAS Standard: 3 & 7

6-I: Recruitment, Hiring, and Retention of a Multicultural Workforce from, or Experienced with, the Identified Unserved and Underserved Populations.

6-I-A: Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.
Rationale: Will ensure continuity across the County Mental Health System.

Workforce Education and Training (WET) Component from the Mental Health Services Act Three Year Integrated Plan for Fiscal Years 2023/2026.

The passage of the Mental Health Services Act (MHSA) in November 2004, provided a unique opportunity to increase staffing and other resources to support public behavioral health programs. MHSA funds increased access to much needed services, and progress toward statewide goals for serving children, Transitional Age Youth (TAY), adults, older adults, and their families.

California's public behavioral health system has suffered from a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides various training opportunities to the Department of Behavioral Health's (DBH) staff and contract agency staff, promotes the hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing workforce shortage within San Bernardino County through utilization of various strategies to recruit and retain qualified behavioral health employees.

WET carries forth the vision of the MHSA to create a transformed, culturally competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

WET MHSA Legislative Goals

Address workforce shortages and deficits identified in the workforce needs assessment:

- Increase in the number of employees hired in identified needs assessment areas
- Increase in pre-licensed to licensed baseline statistics
- Increase in the number of qualified applications received for clinical positions
- Increase in DBH pre-licensed clinicians hired (interns vs. non-interns)

Designate a WET Coordinator:

- WET Coordinator designated

Educate the workforce on incorporating the general standards:

- Training documented addressing these standards
- Training evaluations

Increase the number of clients and family members of clients employed in the public mental health system:

- Increased number of peer and family advocates (PFA's) hired

Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of clients, family members of clients, and others in the community who have serious mental illness and/or serious emotional disturbance:

- Documented efforts that target the identified population
- Documented career fairs including locations

Recruit, employ, and support the employment of individuals in the public mental health system who are culturally and linguistically competent, or at a minimum, are educated and trained in cultural competence:

- Documented efforts that target the identified populations
- Adherence to cultural competency training requirement
- Increase in hiring of culturally competent staff
- Increase in the number of bilingual staff, bilingual applicants, and bilingual interns

Provide financial incentives to recruit or retain employees within the public mental health system:

- Financial incentives implemented

- Tracking for employee scholarship applicants
- License Exam Prep Program statistics

Incorporate the input of clients and family members of clients, and when possible, utilize them as trainers and consultants in public mental health WET programs and/or activities:

- Documented meetings with clients and family members
- Documented trainings facilitated by clients and family members

Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities:

- Documented meetings with diverse racial/ethnic populations

Establish regional partnerships:

- Participate in meetings

WET has continued to perform needs assessments and has initiated an internal 5-year Strategic Plan with the following goals:

1. Identifying gaps in information and skill in the behavioral health community which equips members and staff to effectively perform their duties and enhance job performance.
2. Address identified gaps by offering innovative and evidence-based training which incorporates cutting-edge digital and pedagogical resources in diverse formats to prepare professionals for modern, flexible approaches to behavioral health care delivery.
3. Improve employee retention and foster a positive organizational culture through training for all staff, which also leads to improved succession planning.

6-I-B: Compare the Workforce Needs Assessment data for the WET component of the Plan with the general population, Medi-Cal population, and 200% of poverty data.
Rationale: Will give ability to improve penetration rates and eliminate disparities.

The Department of Behavioral Health (DBH) workforce for FY 2024/2025 was 45.1% Latino, 20.1% Caucasian, 16.7% African American, 7.2% Asian, 0.7% American Indian/Alaska Native, 0.7% Native Hawaiian/Pacific Islander, 6.4% Two or More Races, and 3.2% not specified.

There was a slight increase in DBH's Latino workforce, however Latinos continue to have a disparity as evident by the comparison of the DBH workforce (45.1%) to the general population (55.9%), population under the 200% poverty level (55.9%), Medi-Cal beneficiaries (57.8%), and MHP consumers served (45.5%). When looking at DBH staffing needs, the Latino population is underrepresented. DBH in FY 2024/2025 continued identifying new efforts to address the population disparities through its recruitment and hiring practices.

To address language disparities DBH has made efforts to improve the number of bilingual staff, which has increased by 27.3% from FY 2012/2013 (150) to FY 2021/2022 (191). In FY 2024/2025, 18.2% of DBH's workforce was bilingual (291), slightly lower than the Medi-Cal beneficiary preferred language level of 19.2%.

By comparison, there is a large disparity in the gender makeup of DBH workforce, with male staff being underrepresented. The DBH workforce is 24% male, as compared to the general population (50.0%), population under 200% poverty level (50.0%), Medi-Cal beneficiaries (46.2%) and Medi-Cal Consumers (52.1%).

Table 11: Ethnicity and Gender of DBH Workforce Compared to Populations of Interest FY 2024/2025

	Total Population		**Population under 200% FPL**		**Medi-Cal Beneficiaries**		**Medi-Cal Consumers MHP**		**DBH Workforce**	
	2,195,611		702,596		1,031,841		43,481		1600	
Female	1,098,689		351,580		555,070		20,604		1,209	
Percentage of Females	50.0%		50.0%		53.8%		47.4%		75.56%	
Male	1,096,922		351,015		476,771		22,638		391	
Percentage of Males	50.0%		50.0%		46.2%		52.1%		24.44%	
Other/Unknown		0%		0%	0	0%	239	0.0%	0	0%
Ethnic Group	**Total Population**		**Population under 200% FPL**		**Medi-Cal Beneficiaries**		**Medi-Cal Consumers**		**DBH Workforce**	
African American	165,718	7.5%	53,030	7.5%	99,876	9.7%	6,376	14.7%	267	16.7%
API	187,822	8.6%	60,103	8.6%	54,615	5.3%	917	2.1%	126	7.9%
Caucasian	525,795	23.9 %	168,254	23.9 %	153,047	14.8 %	9,368	21.5%	322	20.1%
Latino	1,226,275	55.9 %	392,408	55.9 %	596,396	57.8 %	19,765	45.5%	721	45.1%
Native American	5,944	0.3%	1,902	0.3%	2,080	0.2%	169	0.4%	11	.7%
Other/ Not Specified	84,057	3.8% %	26,898	3.8%	125,783	12.2%	6,886	15.8%	153	9.6%

6-I-C: If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the Department's review of the WET component of its Plan.

Not applicable.

6-I-D: Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

To address the shortage of licensed clinical positions WET continues to work with the human resource department to recruit for these positions year-round. In FY 2024/2025, there was a decrease in qualified applications received for licensed and pre-licensed positions when compared to FY 2023/2024 (548 compared to 421). In FY 2024/2025, DBH hired 89 pre-licensed clinicians.

DBH has a Medical Education Program and in FY 2016/2017, the program which currently offers rotations to medical students and psychiatry residents, had its first Nurse Practitioner (NP) student complete a psychiatry rotation in DBH clinics. Since then, WET has seen 98 NP students with 6 of those in FY 2024/2025 and 5 scheduled to complete their rotation in FY 2025/2026.

Table 12: Number of Qualified Applications Received for DBH Positions per Fiscal Year in Fiscal Year 2024/2025

Job Title	FY 19-20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Alcohol and Drug Counselor	35	33	45	103	114	97
Child Psychiatrist	10	6	8	5	5	3
Clinic/Care Assistant	73	139	96	N/A	78	173
Clinic Supervisor	19	33	27	55	16	51
Clinical Therapist, LCSW	41	30	14	6	185*	81*
Clinical Therapist, MFT	17	19	7	1	185*	81*
Clinical Therapist, Psychology	0	4	3	2	3	0
Clinical Therapist II	56	58	54	33	33	46
Licensed Vocational Nurse	N/A	N/A	122	63	55	32
Mental Health Education Consultant	35	N/A	23	N/A	65	56
Mental Health Nurse II	64	39	86	22	68	86
Mental Health Specialist	70	70	63	133	87	136
Nurse Manager	35	N/A	N/A	11	2	0
Nurse Supervisor	3	13	1	11	24	16
Peer and Family Advocate I	0	N/A	N/A	N/A	203	483
Peer and Family Advocate II	0	N/A	N/A	N/A	N/A	N/A
Peer and Family Advocate III	0	N/A	N/A	170	N/A	N/A
Pre-Licensed Clinical Therapist, LCSW	41	78	152	464*	351*	276*
Pre-Licensed Clinical Therapist, MFT	40	59	72	464*	351*	276*
Pre-Licensed Clinical Therapist, Psychology	2	32	35	42	32	18
Pre-Licensed Clinical Therapist, LPCC	18	13	37	464*	351*	276*
Program Manager I	30	27	75	34	53	101
Program Manager II	9	19	15	26	25	37
Psychiatric Technician I	20	39	49	71	12	23
Psychiatrist	1	15	12	27	25	36
Research and Planning Psychologist	N/A	N/A	N/A	N/A	N/A	N/A

Source: DBH WET

** Totals for all Clinical Therapists and Pre-licensed Clinical Therapists, could not sort by discipline.*

DBH's Internship and Residency Program provides training opportunities for bachelor's and master's level interns. Internships are available for students in Social Work and Marriage and Family Therapy. DBH also has an APA and APPIC accredited Doctoral-Level Psychology

Internship Program. In FY 2024/2025, there were a total of 52 Social Work, Marriage and Family Therapy, and Psychology Internship Program participants.

The program continues to grow and receive positive feedback from participants who report that they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH. DBH is committed to hiring applicants that were previously interns. In FY 2024/2025, 16% of clinical hires were DBH interns.

DBH has a dedicated Volunteer Services Coordinator who conducts focused outreach to high schools, adult education, community colleges, universities, and Regional Occupation Programs (ROP's) to inform audiences on behavioral health career opportunities, offer volunteer opportunities to individuals interested in behavioral health careers and coordinate outreach to the monolingual Spanish speaking community members. The coordinator has partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helps to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children. The coordinators outreach efforts have resulted in increased internships for diverse psychologists, social workers and marriage family counselors and volunteer opportunities to enter the public mental health field. Working with ROP has also initiated interest in a Mental Health professional focus for ROP. In FY 2024/2025, DBH's Volunteer Services and Outreach program visited 31 schools and reached 7,173 students.

To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen below, there is an increase in the number of bilingual staff who worked at DBH since FY 2012/2013. In FY 2024/2025, there was an increase in bilingual staff s. It remains a top priority of the department to continue to recruit and retain bilingual staff. Bilingual staff accounted for 18.2% of the workforce in FY 2024/2025.

Table 13: Number of Bilingual Staff

FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
165	*162*	*171*	*171*	*170*	*279*	*233*	*209*	*191*	*198*	*247*	*291*

Source: DBH HR

The majority of bilingual staff speak Spanish (97%), but other languages spoken by staff include:

- ASL
- Arabic
- Armenian
- Mandarin/Cantonese
- Tagalog
- Vietnamese

Finally, DBH has a Peer and Family Advocate (PFA) workforce support initiative that supports 55 full time PFA positions (41 on staff and 14 vacancies) throughout DBH. This added diversity builds upon the lived experience and adds a greater dimension to service provision. Once a PFA

starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The following table shows the number of PFAs promoted since 2008.

Table 14: Promoted Peer and Family Advocates from FY 2014/2015 to FY 2024/2025

	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
	3	4	3	5	6	11	2	4	7	7	4

Source: DBH WET

6-I-E: Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

One of the biggest lessons learned is that even if an agency has a solid plan of action for workforce development, unplanned or uncontrolled conditions can make it difficult to carry out even the best of plans. The fiscal crisis of 2010 drastically altered the implementation of the Departments plan and led to a hard-hiring freeze in San Bernardino County. To mitigate these negative aspects of the fiscal crisis, the WET Plan allowed for a more extensive use of WET Plan initiatives such as License Exam Preparation Program (LEPP) courses for clinicians seeking licensure.

The process to get licensure has numerous parts and the license preparation allows for staff to spend the required time on exam preparation in order to improve their chances of successful examination completion. DBH continues to offer LEPP; to date, there have been 13 cohorts of LEPP since 2009 with a 77% (425) licensure rate among 550 applicants.

The WET program experienced the following challenges for FY 2024/2025:

- For a period in FY 2024/2025, the WET program noticed a reduction in training registrations for live courses provided by the WET program. To improve the registration numbers, WET collaborated with the Department of Behavioral Health Public Relations and Outreach Services to develop an exclusive bi-weekly Training Announcement to advertise courses being offered to both department and contract agency employees. Additionally, WET and PROS began working to develop a WET website so there could be a central location for WET related content and information including a dedicated training schedule and direct links to register for the courses offered by WET.
- The DBH Internship Program has experienced challenges in filling its Psychology Mental Health Clinic Supervisor position which provides supervision to the DBH Psychology Program Interns. The lack of applications from qualified applicants has resulted in DBH expanding its efforts to recruit qualified candidates by keeping the job application open on an ongoing basis and by expanding the recruitment efforts to include popular external recruitment websites. Psychology supervision is currently being handled by the DBH internship Program Manager who is a licensed psychologist.
-

The WET program experienced the following highlights for FY 2024/2025:

- An Administrative Supervisor I position was added to Medical Services which includes the residency and nursing training programs.
- THE DBH Marriage and Family Therapy (MFT) Internship Program was able to expand in FY 2024/2025 by successfully launching a Spring cohort resulting in an increase in the total number of MFT Interns that can participate in the program from eight to twelve interns.
- In FY 2024/2025 the 4-Month Post-Training Evaluation was developed by the WET Program to assess the long-term effectiveness of training programs. Its primary goals are to measure information retention, evaluate the application of training content, and determine the relevance and benefits of the training to employees' job roles. By gathering feedback from DBH and Contract Agency employees four months after training, WET aims to understand the sustained impact of the training and how well it meets their current job needs. This evaluation provides insights to improve future training sessions, refine materials, and identify if additional resources, follow-up training, or support are needed. Ultimately, ensuring our training programs remain effective and aligned with the evolving needs of our workforce.
- Intern Program Positions – A Program Manager II, who is a licensed psychologist, was added to the Intern Program to provide oversight of the entire DBH Internship Program. The Psychology, MFT and MSW Internship Program Supervisor positions were reclassified to Mental Health Clinic Supervisor. A Program Manager I was added to oversee SUD interns.

6-I-F: Identify county technical assistance needs.

There are no identified technical assistance needs at this time.

CRITERION 7: LANGUAGE CAPACITY
CLAS Standard: 5, 6 & 8

7-I: Increase Bilingual Workforce Capacity

7-I-A-1: Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs:

To help provide culturally and linguistically competent services to clients, DBH continues actively recruit applicants who are bilingual and bicultural. The department's bilingual language skills need is listed on all job announcements, hoping to capture candidates with various backgrounds and experiences.

In FY 2024/2025, DBH employed 291 bilingual employees accounting for 18.2% of the workforce.

The majority of bilingual staff speak Spanish (97%), but other languages spoken by staff include:
- Armenian
- ASL

- Mandarin/Cantonese
- Vietnamese

7-I-A-2: Updates from the CSS or WET component of the county's Plan on bilingual staff members who speak the languages of the target populations.

The DBH Bilingual Staff List is updated every six months (Attachment A14); please see below for a breakdown of bilingual staff by language and skill level for this fiscal year.

Table 15: DBH Bilingual Staff by Language and Skill Level for FY 2024/2025

	Proficiency			Total
	Verbal	Written	Technical	
Spanish	116	10	161	287
ASL	1	0	0	1
Arabic	1	0	0	1
Farsi	0	0	1	1
Vietnamese	0	0	1	1

Data source: June 2025, DBH HR

7-I-A-3: Total annual dedicated resources for interpreter services in addition to bilingual staff.

In addition to hiring bilingual staff, DBH continued to contract with seven (7) language vendors to provide translation and interpretation services for the contract period of February 1, 2025 to January 31, 2028. The total budgeted amount for the contract is $3,900,000. This allocation of resources does not include the bilingual pay differential paid to certified (tested) bilingual employees (Verbal: $50 per pay period, Technical: $60 per pay period and $45 for Management and Exempt bilingual employees) which totaled $353,124.63 in FY 2024/2025.

7-II: Provide Services to Persons who have Limited English Proficiency (LEP) by using Interpreter Services.

7-II-A: Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

- **A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.**
- **Consider use of new technologies such as video language conferencing. Use new technology capacity.**
- **Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.**
- **Training for staff that may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.**

A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals:

DBH provides and maintains 24-hour Access & Referral Lines for all clients. The line links callers to behavioral health services, responds to urgent conditions, and provides beneficiary problem resolution through grievances and appeals.

- Medi-Cal members seeking specialty mental health (SMH) services are directed to call the 24/7 Access Line at (888) 743-1478 (TTD and TDD services are available).
- Drug Medi-Cal clients seeking Substance Use Disorder (SUD) services are directed to call the SUD Beneficiary Access Line at (800) 968-2636 (TTD and TDD services are available).

DBH's Access & Referral Lines are equipped, and required to, provide language services and interpretation for all individuals through bilingual staff or through one of the six (6) contracted language services providers. It is the department's policy to ensure beneficiaries have access to appropriate linguistic services and ensure beneficiaries are made aware of these services offered for both mental health and substance use disorder services. This information is located in the Integrated Behavioral Health Member Handbook all members receive, and information is posted at all department locations.

The Integrated Behavioral Health Member Handbook is posted on the DBH Website https://wp.sbcounty.gov/dbh/resources/ in English, Spanish, Mandarin, Vietnamese and in larger print. Hard printed copies are available at all department locations.

DBH has in place a 24/7 Access Line Requirements Policy and Procedure (QM6045 and QM6045-1) that can be located on the DBH website Documents – DBH Internet Website (sbcounty.gov), under the Standard Practice Manual tab.

Consider use of new technologies such as video language conferencing. Use new technology capacity:

The Office of Equity and Inclusion (OEI) continues to implement the use of video interpretation and has invested in video equipment and hardware for the network infrastructure to provide a reliable and stable video signal to the six major clinics in San Bernardino County.

Current Process:

The seven language service vendors for DBH provide video (image and voice) interpretation services. In 2024, a video interpretation platform was implemented at six (6) different clinic locations throughout the county.

Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access including staff training protocol:

In FY 2024/2025, when a speaker with Limited English Proficiency called the county's statewide toll-free number during business hours or after hours the call went to the DBH Access Unit which is staffed with Spanish Bilingual staff and staff who are trained to connect to a Language Vendor for Non-English Languages. Contract providers refer after hours calls to the DBH-operated 24/7 Access Line and SUD Beneficiary Access Line to ensure appropriate access, tracking and reporting to DHCS. DBH has in place a 24/7 Access Line Requirements Policy (QM6045) and Procedure (QM6045-1) to ensure protocol is followed.

Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

DBH provides live training to all staff during New Employee Orientation on how to interact and connect non-English speaking clients either at the clinic or on the phone to appropriate language services. This training focuses on the Spanish language, but also been includes Mandarin, Vietnamese and how to utilize the California Relay Service (CRS). The training is to ensure appropriate language linkage when clients/family members are present in person or on the telephone. The training includes the distribution of a Language Service Guide for Translation/Interpretation (Attachment A15) which includes how to access language services both during daytime hours as well as after hours. Written and phonetic pronunciation guides for Spanish, Vietnamese and Mandarin were added to the Language Services Guide for Translation/Interpretation to ask a person to hold and the One Moment Please phrase while an approved bilingual staff or vendor is connected to the requestor (over the phone or in person). The oral interpretation is available on the DBH staff website for Spanish, Mandarin and Vietnamese for staff to practice and use. Trainings were provided to the DBH-operated 24/7 Access Line and SUD Beneficiary Access Line staff on how to connect callers to a vendor if no bilingual staff are available.

7-II-B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.

Clients are informed at all points of access about their language rights. A language rights poster and a language identification poster are posted in all department sites.

7-II-C: Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services.

The Department of Behavioral Health (DBH) has the full capacity to accommodate Limited English Proficient (LEP) clients, see policy CUL1004: Satisfying Clients' Language Needs. Procedure CUL 1012: Providing Interpretation Services Procedure outlines steps to access an interpreter, including bilingual staff as well as contracted language service providers. A list of bilingual-paid staff is generated every three to six months and made available for staff's reference.

7-II-C-1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

Starting in FY 2024/2025, Office of Equity and Inclusion (OEI) actively gathered feedback from DBH Clinic and Program locations who are the highest utilizers of language services. Based on feedback received, OEI provided multiple virtual and on-site trainings to ensure DBH staff had the proper tools to request services, culturally competent terminology in Spanish, and interactions with the vendors. OEI established better communication with the seven vendors and provided technical assistance, feedback and problem resolution to improve services to clients, family members and stakeholders. In FY 2025/2026, OEI will actively work with the rural/desert utilizers of language services to continue to provide culturally appropriate services to LEP's, family members and stakeholders.

7-II-D: Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

Challenges and Efforts (A):

- The implementation of the Video Interpretation Project experienced setbacks due to improper use of the original technology and a lack of understanding on what was needed to fully support the overall project in a technical manner.
- Collaboration between DBH Information Technology, County Purchasing and OEI was fundamental in understanding what equipment was needed, its use within the project and the limitations the hardware presented when installed.

Lessons learned (A):

- Develop better methods to control use and monitor outcomes.
- Need a standardized reporting process.
- Training and education needed on the use of services for staff and clients.

Challenges and Efforts (B):

- Clinic staff are unaware of the availability of access to language services or when services are updated.
- Short appointment time frames.
- Staff and clients are unaware of how to access or explain language services.

Lessons learned (B):

- Frequent and ongoing language services training for staff and contact services providers.
- Notifying staff and removing old information when services are updated. Updating policies and staff reference sheets.

Challenges and Efforts (C):

- Clinic staff are unaware of the availability of access to language services or when services are updated.
- Short appointment time frames and limited availability due to location.
- Staff and clients are unaware of how to access or explain language services.

Lessons learned (C):

- Frequent and ongoing language services training for staff.
- Actively engaged and troubleshooted with contact services providers to ensure availability.
- Notify staff to maintain communication with vendors to not impact appointments or services.

7-II-E: Identify county technical assistance needs.

Guidance on effective alternative formats to written information for individuals who are visually impaired.
List of verified vendors to certify bilingual staff in threshold and prevalent non-English languages for contract providers.
Clear guidance on written/printed materials reading grade level requirements, clearly outlining mandate.

7-III: Provide Bilingual Staff and/or Interpreters for the Threshold Languages at all Points of Contact.

Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

7-III-A: Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

Bilingual staff and interpreter vendors are available in languages spoken by the community. Staff who receive bilingual pay are kept on a Bilingual Staff master list that is updated and kept on the county intranet DBH site. This list is utilized first when a non-English speaking clients/family member or community member accesses service. Every effort is made by staff to accommodate need to the point of traveling between sites to provide language services, if needed. The next level of language service delivery is via a language vendor. In FY 2024/2025, DBH has contracts with seven (7) language vendors for translation and interpretation services. Language posters are present at all clinic sites and state that language services are free and available.

7-III-B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

Interpreter services are offered to clients/family members and their response to the offer is recorded in their chart. The Outpatient Chart Manual describes the exact process of documenting interpreter services offer and requests on page 119 in the following link: https://www.sbcounty.gov/uploads/DBH/2021/08/outpatientchartmanual_11-5-19_AC.pdf

7-III-C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

DBH bilingual and contacted language services vendors are available 24/7/365 in the county's threshold languages. DBH bilingual staff proficiency is tested by the county Human Resources Department. Contract language vendors provide evidence of their staff's proficiency in threshold languages in their proposals to provide services and as requested by the county.

7-III-D: Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

To ensure that DBH bilingual staff is linguistically proficient, they must pass a verbal and or technical exam. This process is initiated through the county Human Resources (HR) Department, as opposed to DBH Human Resources Department. There are two (2) stages of bilingual testing. Verbal testing is multiple choice-booklet format and tests comprehension, grammar and idiomatic expression in a multiple-choice format. The second tier of examination tests the user's ability to orally translate expressions frequently found in a clinical or judicial environment. The user must be able to translate efficiently and think in a quick manner to be successful. The level a staff member is tested for depends on their job classification and job duties. The department has in place a Bilingual Certification Policy (HR4031) that provides guidance on designation of positions and certification expectations for individuals that desire to become county-certified.

7-IV: Provide Services to all LEP Clients not Meeting the Threshold Language Criteria who Encounter the Mental Health System at all Points of Contact.

7-IV-A: Policies, procedures, and practices the county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

The Department of Behavioral Health (DBH) has policies and procedures in place that address service delivery for LEP consumers/family members who may not meet the threshold language criteria.

- Behavioral Health Services for Clients/Family Members Who are Deaf of Hard of Hearing Policy: CUL1002
- Behavioral Health Services for Clients/Family Members Who are Deaf of Hard of Hearing Procedure: CUL1002-1
- Satisfying Clients' Language Needs Policy: CUL1004
- Providing Translation Services Procedure: CUL1011
- Providing Interpretation Services Procedure: CUL1012
- Providing Written Communications in Threshold/Primary Languages for Consumer/Family Members Policy: CUL1013
- Non-Discrimination-Section 1557 of the Affordable Care Act Policy: COM0953
- Affordable Care Act (ACA) 1557 Grievance Procedure: COM0953-1
- Written Informing Materials Policy (QM6012)

All policies listed above can be accessed on the DBH Website located at https://wp.sbcounty.gov/dbh/forms/ under the Standard Practice tab.

7-IV-B: Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

Clients who do not meet the threshold language criteria are appropriately linked to bilingual certified staff. If there is no staff available, DBH staff will utilize a vendor to provide appropriate language services. For the specific process for engaging an interpreter, please refer to procedure CUL 1012: Providing Interpretation Services Procedure. The department has four threshold languages: English, Mandarin, Spanish and Vietnamese. In FY 2024/2025, OEI translated numerous Written Informing Materials into all Threshold Languages which are posted on the DBH website: https://wp.sbcounty.gov/dbh/resources/.

7-IV-C: Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 requirements:

- **Prohibiting the expectation that family members provide interpreter services;**
- **A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and**
- **Minor children should not be used as interpreters.**

The aforementioned requirements are addressed in DBH policy COM0953: Non-Discrimination – Section 1557 of the Affordable Care Act Policy, DBH procedure COM0953-1: Affordable Care Act (ACA) 1557 Grievance Procedure and DBH policy QM6012: Written Informing Materials Policy.

CRITERION 8: ADAPTATION OF SERVICES

CLAS Standard: 12

8-I: Client-Driven/Operated Recovery and Wellness Programs.

8-I-A: List client-driven/operated recovery and wellness programs.

San Bernardino County Department of Behavioral Health (DBH) has an extensive client driven/operated recovery and wellness program.

DBH has ten (10) client clubhouses and five (5) One Stop Transitional Age Youth (TAY) Centers which employ Peer and Family Advocates (PFA's) who are culturally and linguistically representative of the clients served throughout the DBH system of care.

DBH and Contracted Providers currently operate ten (10) clubhouses in the following areas:

- A Place to Go Clubhouse – Lucerne Valley
- Amazing Place – Ontario
- Central Valley FUN Clubhouse – Rialto
- Desert Stars – Barstow
- Pathways to Recovery – Fontana
- Hopeful Horizons – Yucca Valley
- Serenity Clubhouse – Victorville
- TEAM House – San Bernardino
- Spike's Clubhouse – Needles
- C.A.R.E. Center (Consumer Advocacy & Recovery Engagement Center) Clubhouse - Yucaipa

DBH and Contracted Providers will be opening additional clubhouses in late 2025 in the following areas:

- Apple Valley

DBH and Contracted Providers operate five (5) One Stop TAY Centers in the following areas:

- Barstow
- Ontario
- San Bernardino
- Victorville
- Yucca Valley

See DBH Services Guide for full listing and addresses: https://wp.sbcounty.gov/dbh/resources/

DBH has a Peer and Family Advocate (PFA) program with the goal of increasing the number of individuals with behavioral health lived experience employed in the public mental health and

substance use system. PFA's are individuals with the lived experience of being behavioral health clients or family members of behavioral health clients. PFAs provide system navigation, crisis response services, peer counseling, linkages to services, and support for individuals accessing behavioral health services. In FY 2024/2025, DBH had fifty-five (55) Peer and Family Advocate positions. These positions are staffed in 26 different programs.

In FY 2024/2025 with the passage of SB 803 Peer Support Specialist Certification Program DBH continued implementation with the California Mental Health Services Authority (CalMHSA) as the entity that will represent counties for the implementation of a State approved Medi-Cal Peer Support Specialist Certification Program, to support consistency statewide. Medi-Cal Peer Support Specialist Certification makes it possible for certified peer support specialists to be eligible for Medi-Cal reimbursement through county mental health and substance use disorder plans. All DBH Peer and Family Advocates will be trained and certified to ensure consistency of service delivery across DBH programs and services. The passage and local implementation of Peer Support Specialist Certification increases the opportunity for DBH programs and services to be informed and adapted by individuals with lived experience to meet the unique needs of person in care or seeking care. As of November 2025, 23 currently employed Peer and Family Advocates have received certification. In FY 2024/2025 DBH established a peer program unit. This unit developed a bimonthly Peer Engagement meeting to provide ongoing support to certified and non-certified peers. The Peer Program division is in process of developing an engagement network for Supervisors of peer staff and is planning for a Peer Summit in 2026.

DBH has the Office of Equity and Inclusion (OEI) has three (3) PFA's. The PFA's provide support to clients and their families by linking them to appropriate services for treatment and assist individuals and families in navigating the departments vast behavioral health system. OEI staff facilitate the Cultural Competency Advisory Committee (CCAC) Consumer and Family Members Awareness Subcommittee and conduct yearly trainings on consumer/family member culture.

DBH has in place four (4) Recovery Centers throughout the county. Recovery Centers' primary purpose is to support the recovery efforts from substance use disorders of persons in the communities of San Bernardino County. Recovery Centers provide a supportive substance free environment where persons in recovery and those seeking support in their recovery process can work with one another to secure resources that will help sustain and strengthen their wellness efforts. The objective of Recovery Centers is to provide comprehensive efficient supportive strategies to assist in the ongoing prevention of substance use disorders and relapse. Recovery Centers provide substance-free alternative activities, information dissemination, vocational and educational opportunities, training classes, and medically necessary Recovery Services. Recovery Centers offer community members a safe and sober environment to receive continuous mutual support, relapse prevention services, psychoeducation, family education/ family life counseling and support, and life skills groups, such as:

- Inland Valley Recovery Services Central Valley Recovery Center – Colton
- Inland Valley Recovery Services San Bernardino Recovery Center – San Bernardino
- Rim Family Services Recovery Center – Skyforest
- Inland Valley Recovery Services Upland Recovery Center – Upland

Recovery center groups are led by Alcohol and Other Drug (AOD) counselors. Recovery Centers employ Peer Support Staff, which are persons who are successfully in recovery or have personal experience with family members who have had substance use disorder issues. Peer Support Staff

are formally trained, are familiar with others' addiction challenges and are familiar with their communities need for support to live a life free of alcohol and drugs. Their personal life experiences and/or of those in their families with addictions have a significant contribution in the recovery process of others.

All these programs use the Recovery, Wellness, and Resilience model in a stigma free environment.

8-I-A-1: Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.

Clubhouses, One Stop TAY Centers, and Recovery Centers provide recovery-oriented programs using a Recovery, Wellness, and Resiliency model in stigma free environments for adult and transition age youth clients living with serious mental illness and substance use issues. The main objective of these programs is to assist clients of diverse racial, ethnic, cultural, and linguistic backgrounds in making their own choices and integrating into the community as contributing members, thereby achieving optimum wellness. All programs are voluntary and accommodate clients/members individual preference and respect racially, ethnically, culturally, and linguistically diverse differences. This is done from staff hiring to program development and program delivery. Clubhouses and One Stop TAY Centers incorporate peers and members into staff hiring panels. All programs provide peer led groups and provide an array of services to meet the needs of clients/members.

In FY 2024/2025, clubhouse provided services to 3,084 unduplicated consumers. The demographic breakdown of the consumers shows that a diverse population is served: 18% of consumers were African American, 37% were Caucasian, 3% were Native American, 3% were Asian/Pacific Islander, 36% were Latino/Hispanic and 3% other.

Clubhouses have seen an increase in the number of consumers seeking services who are unhoused. In response to this, peer governing boards have continued to adapt how they support their peers by implementing a variety of resources specific to the needs of this demographic. This has included shower/laundry access, locked phone charging stations, increased hygiene support, emergency clothing, extreme weather resources such as ponchos, hand warmers and blankets, daily nutrition support, daily living skills groups, housing navigation and other regionally needed supports. In FY 2024/2025 contracts for community providers of clubhouse locations were also expanded to require these supports. In FY 2024/2024 all facilities have added or are in process of adding these supports.

Clubhouses continue in-person educational events celebrating diverse culture such as Black History Month event, Pride event, Lunar New Year Celebration and Dia de los Muertos. All Clubhouse staff additionally received sexual orientation and gender identity training and incorporated this training into daily clubhouse education for consumers.

As a result of the increasing demands for supporting consumers experiencing substance use, in FY 2022/2023 full time Alcohol and Drug Counselor positions were added to the staffing pattern for county-run clubhouses. In FY 2024/2025 hiring began for these positions. Currently one (1) position in the high desert has onboarded and two more are in the hiring process. All locations

have implemented harm reduction groups, offer onsite NA and AA meetings or linkage to offsite meetings and are community Narcan Distribution Centers.

The main objective of the One Stop TAY Centers is to provide San Bernardino County residents ages 16 to 25 with outpatient mental health, case-management and placement services. One Stop TAY Centers coordinate the transition of youth from child to adult services and assist youth in adjusting to the new, adult environment. One Stop TAY Centers served 427 FSP clients in FY 2024/2025. The demographic breakdown for One Stop TAY Centers is as follows: 16.4% of clients were African American, 49.4% Latino, 22.5% Caucasian, 3% Asian, and 9% Other.

The Consumer and Family Members Awareness subcommittee meets monthly, with participants from a diverse array of cultural backgrounds. The purpose of the subcommittee is to bring forward issues faced by consumers and their family members to the Office of Equity and Inclusion and the Equity and Cultural Competency Officer, who in turn brings such ideas to the executive team to address within the system of care. The Chair also participates at monthly CCAC meetings and events, see CCAC Annual Report for accomplishment.

DBH and their subcontractors are required to serve all racial/ethnic groups and other diverse people groups, while also maintaining staff that are as diverse as the populations they serve to improve and maintain overall quality of services and outcomes. Additionally, all staff, including contract employees, who provide direct services are required to participate in a minimum of four (4) hours of cultural competency training annually. Substance Use and Recovery Services (SUDRS) Division provides oversight to all Recovery Centers, and Inpatient and Outpatient SUD (Substance Use Disorder) Treatment Providers. Program coordinators complete quarterly reviews on all certified treatment programs and up to two yearly program reviews: semiannual and annual at the Recovery Center's site. The audit tool records verification of cultural competency trainings per employed staff.

8-I-A-2: Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

Clubhouses and One Stop TAY Centers are peer-driven support centers for members in recovery. Clubhouses are operated by the members through peer-elected governing boards. One Stop TAY Centers also have boards that provide input in the delivery of services at One Stop TAY Centers.

The various growth opportunities and activities available to the diverse clubhouse and One Stop TAY Center members aid in increasing members' ability to integrate and cope within the community. Clubhouses and One Stop TAY Centers also sponsor regularly scheduled social and recreational activities, both in the community and on-site, which increases the members' ability to interact and develop skills that improve their ability to function in the community. These activities are mostly decided on by the clubhouse and One Stop TAY Center members, and so they take into consideration options that accommodate individual preference and cultural/linguistic differences.

Clubhouses and One Stop TAY Centers provide growth opportunities and activities for members, such as:

- Living skills
- Volunteerism
- Job skills
- Community integration excursions

- Canteen and clothing closet operations
- Nutrition and cooking
- Physical health education
- Housing and maintaining housing
- Behavioral health education
- Co-occurring education
- Recovery and Support from Substance Use
- Cultural Awareness Events
- Consumer Evaluation Council
- Stakeholder Engagement support
- Hygiene supports
- Community connection support such as employment, education or volunteering.

SUDRS Programs employ Peer Support Staff, which are individuals who are successfully in recovery and/or have specific experience with family members who have had substance use disorder issues. Effective July 1, 2022 Peer Support Specialist Certification program was implemented and made available to all Peer Support staff who qualify. In addition, some of SUDRS programs allow their regular members the opportunity to lead some of the Recovery Center's activities and serve as a resource for selective individuals to complete required community service hours; when appropriate. DBH Clubhouses now have certified Alcohol or Other Drug (AOD) Counselor positions within their facilities. AOD Counselor's support participants and provide psychoeducational groups regarding substance use and can assist them navigate our system of care when any of them need SUD treatment services. These practices widen the opportunities and doors for a more racially, culturally, and linguistically specific participants.

8-II: Responsiveness of Mental Health Services

8-II-A: Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.

Provider Directories and a Services Guide are provided and available to clients for their personal accommodation of preference, or cultural/linguistic needs. The directory provides options for clients/family members. Directories are available in threshold languages and alternate formats.

Mental Health Plan Organizational/Rendering Provider Directory
https://wp.sbcounty.gov/dbh/resources/

Substance Use Disorder and Recovery Services Provider Directory
https://wp.sbcounty.gov/dbh/resources/

Services Guide
https://wp.sbcounty.gov/dbh/resources/

Furthermore, the Department of Behavioral Health provides several culturally specific programs, both county-operated and through contract agencies, including but not limited to:

- Resilience Promotion in African American Children: Provides prevention and early intervention services to African American children/youth (ages 5-18) and their families.
- Culture-Specific Community Health Worker/Promotores de Salud Programs: A prevention program designed to address the needs of San Bernardino County's culturally diverse communities. The program increases community awareness and connection to community-based prevention and behavioral health services without fear of discrimination or stigma. Services are specifically targeted at underserved and unserved groups, including Spanish speaking communities, African American communities, Asian/Pacific Islander communities, Native American Communities, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities.
- Native American Resource Center: A one-stop center offering several prevention and early intervention services for Native American community members of all ages. The center provides services that incorporate traditional, strength based, Native American practices.
- One Stop TAY Centers: Provide integrated behavioral health services to individuals aged 16 to 25 with behavioral and/or emotional problems.
- Age Wise Program: Provides intensive case management services for older adults.
- The Military Services and Family Support Program (MSFS) a prevention and early intervention program that provides mental health services to military veterans, active duty and retired military personnel, reservists, and members of the National Guard who served on or after September 11, 2001, and their families, throughout San Bernardino County. Services address the negative effects of traumatic events and other unique challenges of military life; services are provided in-home and/or in the community. In FY 2019/2020 as a result of overwhelming stakeholder and community feedback, the MSFS program was expanded to include all military service members.

8-II-B: Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

DBH's Services Guide and Provider Directories contain the information on the availability and location of all providers.

8-II-C: Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. (Outreach requirements as per Section 1810.310, 1A and 2B, Title 9):

DBH's Public Relations and Outreach Services (PROS) office works in conjunction with the Office of Equity and Inclusion (OEI) to outreach to diverse communities of San Bernardino County. DBH has developed the following policies and procedures on the development of materials to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services and substance use disorder services.

- Guidelines for Promotional, Educational and/or Informational Materials: BOP3031
- Web Blast Policy: BOP3045
- Web Blast Procedure and Guidelines: BOP3045-1
- Request to Change the DBH Websites Policy (BOP3047)
- Request to Change the DBH Websites Procedure (BOP3047-1)
- Guidelines for Promotional, Educational, and/or Informational Materials (BOP3031)

- Providing Written Communications in Threshold/Primary Languages for Consumer/Family Members Policy: CUL1013
- Written Informing Materials Policy: QM6012

Please refer to **Criterion 1** for a description of outreach activities conducted by PRO and OEI.

8-II-D: Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

- **Location, transportation, hours of operation, or other relevant areas;**
- **Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and**
- **Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)**

OEI conducts Mental Health Plan Test Calls to DBH and contract provider facilities. The purpose of the calls is to ensure accurate information to services and access to appropriate language services.

OEI conducts Mystery Shopper Calls for the Substance Use Disorder and Recovery Services (SUDRS) program. Calls are made to DBH and contracted providers to assess for linguistic capabilities, ADA accessibility and alternative Medication Assisted Treatment (MAT) services.

Test calls and Mystery Shopper calls are part of the DBH's Quality Improvement Performance Plan activities and will continue for FY 2024/2025 plan can be located on the DBH website Quality Management – DBH Internet Website (sbcounty.gov). The FY 2024/2025 Quality Improvement Plan Evaluation will be posted by June 30, 2026 on the DBH website Quality Management – DBH Internet Website (sbcounty.gov).

Another way the county assesses the ease with which culturally and linguistically diverse populations can obtain services is through annual program reviews and compliance reviews. When county staff conduct program reviews, they review the programs policies, procedures and practices to provide culturally and linguistically competent services as outlined in their contracts.

DBH contracted providers are contractually required to satisfy the following Cultural Competency requirements:

- Contractors shall participate in the county's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. In addition, contract agencies will maintain a copy of the current DBH CCP.
- To ensure equal access to quality care for diverse populations, contractors shall adopt the federal Office of Minority Health Cultural and Linguistically Appropriate Service (CLAS) national standards.

- Contractors shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective mental health and substance use disorder treatment services.
- Upon request, provide DBH with culturally specific service options available to be provided by the contractor.
- Contractors shall have the capacity or ability to provide interpretation and translation services in threshold and prevalent non-English languages, free of charge to beneficiaries.
- Contractors shall provide written informing materials in alternate formats and in threshold and prevalent non-English languages.
- Contractors shall have in place strategies to recruit, promote, and support a culturally and linguistically diverse workforce that is representative of the demographic characteristics of the population in the service area.
- Contractor shall have in place procedures to determine if their staff is multilingual/bilingual and their competency level.
- Contractors shall have in place procedures notifying beneficiaries of interpretation services, auxiliary aids and services, which must be available to them free of charge.

The items above are in the program review tools and assessed for each contractor. DBH staff must assess whether the contractor has implemented the item, if the item needs improvement, or if immediate action is required. When contractors are found to need improvement or immediate action on specific cultural competency items, county staff includes the findings in a Corrective Action Plan, which contractors must address within a specific time frame.

Another way the county assesses factors and develops plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services is during the annual MHSA community planning process and monthly MHSA Community Policy Advisory Committee (CPAC) meetings. OEI in collaboration with CCAC carve out a specific time during each of the fourteen (14) subcommittee meetings to elicit feedback on challenges in relation to clinic or service providers' locations, hours of operation, and other access issues. This information is then provided to MHSA staff and utilized to improve MHSA services in the future. See the MHSA Three Year Integrated Plan , pages 25 through 26, for listing of meeting where MHSA programs presented to CCAC and subcommittees Mental Health Services Act (MHSA) – DBH Internet Website (sbcounty.gov).

Family Resource Centers (FRCs) are an example of a setting that is non-threatening and reduces stigma. FRCs offer a variety of prevention and early intervention services supporting the health and wellness of individuals and families. FRC locations within local communities allows services to be tailored to the specific needs and cultural requirements of individualized communities. Early intervention eligibility requires a participant's diagnosis be a mild to moderate behavioral health condition that is treatable with low-intensity interventions that can improve within one year. Services include After school youth projects and activities, Behavioral health education workshops, Maternal mental health, Personal development activities, Skills-based education for adults, Family counseling, Individual therapy, and Case management services.

8-III: Quality of Care: Contract Providers

8-III-A: Evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

As part of the procurement or formal bid process, DBH maintains cultural competence requirements and guidelines. DBH defines Cultural Competency or Cultural Relevance as the acceptance and understanding of cultural mores, history, language, race, ethnicity, and culture and their possible influence on the client's issues and/or behavior, that is, using the understanding of the differences between the prevailing social culture and that of the client and their family to aid in developing individualized supports and services.

Submitted proposals by providers are evaluated on the following items specific to cultural competence:

- The agency's ability to understand the population they are proposing to serve and how to best meet their needs.
- A detailed description in the form of an implementation plan as to how the agency will provide services in culturally competent manner by recruiting, hiring, and maintaining staff members who can provide services to a diverse population. This includes ensuring that the agency's staff completes training in cultural competency annually. Administrative staff that does not provide direct services to clients shall complete two hours of cultural competency training annually. Direct service and clinical staff shall complete a minimum of four hours of cultural competency training annually.
- Each agency must describe how they will provide services in the appropriate language and in a culturally competent manner. This aids in establishing community-wide collaboration in service design and system evolution, including clients, formal and informal supports, mental health, criminal justice system, education, social welfare, and cultural stakeholders in the community. The provision of culturally competent services by tailoring responses to family culture, values, norms strengths, and preferences. Ensuring services are culturally competent and respectful of the culture of participants and their families.
- Cultural values and norms should be included in assessments for the analysis of relevant cultural issues and history and in the Individualized Service Plan as the plan should reflect the best possible fit with the culture, value and beliefs of the client.
- Agencies' goals include providing services appropriate to need based on functioning and cultural background.
- Agencies will gather demographic information on their services for service planning.
- The number of required staff fluent in other languages is dependent upon the community being served; however, it must be sufficient to accomplish services.
- Inclusion of the above-mentioned items will help to ensure program services are culturally competent and inclusive of individual values and norms.

All DBH contracts have the following standard language:

A. Cultural Competency

The State mandates counties to develop and implement a Cultural Competency Plan (CCP). This Plan applies to all DBH services. Policies and procedures and all services must be

culturally and linguistically appropriate. Contract agencies are included in the implementation process of the most recent State approved CCP for San Bernardino County and shall adhere to all cultural competency standards and requirements. Contractor shall participate in the county's efforts to promote the delivery of services in a culturally competent and equitable manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. In addition, contract agencies will maintain a copy of the current DBH CCP.

1. Cultural and Linguistic Competency

   Cultural competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations.

   a. To ensure equal access to quality care for diverse populations, Contractor shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) national standards.

   b. Contractor shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective mental health and substance use disorder treatment services.

   c. Upon request, Contractor shall provide DBH with culture-specific service options available to be provided by Contractor.

   d. Contractor shall have the capacity or ability to provide interpretation and translation services in threshold and prevalent non-English languages, free of charge to beneficiaries. Upon request, Contractor will provide DBH with language service options available to be provided by Contractor. Including procedures to determine competency level for multilingual/bilingual personnel.

   e. Contractor shall provide cultural competency training to personnel.

      NOTE: Contractor staff are required to complete cultural competency trainings. Staff who do not have direct contact providing services to clients/consumers shall complete a minimum of two (2) hours of cultural competency training, and direct service staff shall complete a minimum of four (4) hours of cultural competency training each calendar year. Contractor shall upon request from the county, provide information and/or reports as to whether its provider staff completed cultural competency training.

   f. DBH recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the

importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. Providing mental health and substance use disorder treatment services in a culturally appropriate and responsive manner is fundamental in any effort to ensure success of high quality and cost-effective behavioral health services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers does not reflect high quality of care and is not cost-effective.

g. To assist Contractor's efforts towards cultural and linguistic competency, DBH shall provide the following:

i. Technical assistance to Contractor regarding cultural competency implementation.

a) Monitoring activities administered by DBH may require Contractor to demonstrate documented capacity to offer services in threshold languages or contracted interpretation and translation services.

b) procedures must be in place to determine multilingual and competency level(s).

ii. Demographic information to Contractor on service area for service(s) planning.

iii. Cultural competency training for DBH and Contractor personnel, when available.

iv. Interpreter training for DBH and Contractor personnel, when available.

v. Technical assistance for Contractor in translating mental health and substance use disorder treatment services information to DBH's threshold languages. Technical assistance will consist of final review and field testing of all translated materials as needed.

vi. The Office of Equity and Inclusion (OEI) may be contacted for technical assistance and training offerings at cultural_competency@dbh.sbcounty.gov or by phone at (909) 252-5150

8-IV: Quality Assurance Requirement: A description of current or planned processes to assess the quality of care provided for all consumers under the consolidation of specialty mental health and substance use services. The focus is on the added or unique measures that shall be used or planned in order to accurately determine the outcome of services to consumers from diverse cultures including, but not limited to, the following:

8-IV-A: List, if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.

Client outcomes are collected by various survey tools as well and consumer/client led evaluation and quality improvement efforts.

The following tools are utilized to address cultural/linguistic issues in addition to other items:

- Mental Health Plan Consumer Perception Survey: Surveys are facilitated once per year in May. Three (3) specific questions are used to measure customer satisfaction in regard to culturally appropriate customer service and written information for adults (including older adults). The surveys were available in the counties threshold languages. The surveys are accessible on paper and electronically. Surveys and latest results are available here Documents – DBH Internet Website (sbcounty.gov). Survey results are also here Patients' Rights – DBH Internet Website.
    - Five (5) specific questions are used to measure customer satisfaction in regard to culturally appropriate services customer service and written information for youth.
- Substance Use Disorders Treatment Perceptions Survey: Surveys are facilitated once a year in October. One (1) question is used to measure culturally appropriate customer service. The survey is available in the counties threshold languages and available here Treatment Perceptions Survey (TPS)
- Transformation Collaborative Outcomes Management (TCOM): DBH utilizes the following TCOM assessment tools which include items to measures client's strengths and needs in relation to culture.
    - ANSA: Adults Needs and Strengths – San Bernardino (ANSA-SB)
      The manual can be downloaded here: Adult Needs and Strengths Assessment San Bernardino The scoresheet can be downloaded here: Adult Needs and Strengths - ANSA-SB
    - CANS: Child and Adolescent Needs and Strengths – San Bernardino (CANS). The manual can be downloaded here: Microsoft Word - 2021.01.27_REFERENCE GUIDE_San Bernardino CANS 3.0_CWBH_FINAL.docx The scoresheet is here: CANS - Scoresheet
- In FY 2024/2025, the Clubhouse and Community Connections Program, in partnership with DBH Research and Evaluation (R&E), and the Consumer Evaluation Council (CEC) launched the Consumer Empowerment Evaluation. This is a consumer designed evaluation tool that is facilitated and evaluated by the CEC members.
    - The Council is comprised of clubhouse consumers and peers from all regions with support from Clubhouse and R&E Staff. The CEC meets monthly for evaluation of outcomes measures, design of additional qualitative outcome metrics and development of stakeholder input on DBH presented items. The group provides valuable insight and feedback related to existing and newly proposed outcomes metrics, which are then integrated into department planning and changes.
    - The CEC has also been and continues to be instrumental, offering wisdom on areas and topics that are meaningful to them and not currently being measured in departmental outcomes, sharing potential ways those pieces of information and story can be included moving forward.
    - The CEC also provides direction at various outcomes-related, and quality-improvement focused departmental meetings (e.g., QMAC, CPAC, BHC) as well as offer guidance and consumer considerations to be integrated into both process and outcomes improvements.
    - In 2021, the Consumer Evaluation Council won a National Association of Counties (NACo) Achievement Award.

Abstract: The San Bernardino County Department of Behavioral Health's (DBH) Consumer Evaluation Council (CEC) addresses the need to include feedback from individuals with lived experience in mental health and substance use disorders, also known as consumers, in research and evaluation efforts. The program brings together consumers of different ethnicities and diagnoses, from all regions of the county, to regularly gather input and provide feedback on the creation and evaluation of DBH programs and services. The CEC empowers consumers to inform the department's improvement projects including surveys, research and evaluation designs, quantitative and qualitative methodologies, innovation program development, and quality management improvement projects. Encouraging consumers to take charge of evaluation design, participate in meetings, and provide their honest feedback is also a supportive factor in the recovery process. The creation and support of a CEC is a powerful and successful way for counties to elevate and increase inclusivity of the consumer experience in all aspects of service delivery, research, evaluation, and quality improvement projects. The CEC is also proposed as a formal business process, wherein all research and evaluation designs, metrics, and analysis are brought to the CEC for their feedback and integration into these areas.

- In FY 2024/2025 clubhouses will continue carrying out their own processes to acquire internal feedback from their members. The purpose of this is identify any strengths or areas of improvement, with all comments being reviewed quarterly by the CEC. Decisions are then made whether input can be addressed, must be made at the systemic level, or referred to Clubhouse Staff and/or the Consumer Board for further review.

- Lastly, in FY 2024/2025, CEC members began receiving compensation for their contributions to the community planning process throughout DBH (e.g., CPAC, QMAC, BHC) as well as their efforts in carrying out activities related to the empowerment evaluation. As of June 2025, DBH has issued over $9,000 dollars in gift cards to the CEC members as compensation for their contribution.

DBH's Quality Improvement Performance Plan includes a section to monitor and assess quality of care. Section 4: MONITORING BEHAVIORAL HEALTH NEEDS IN SPECIFIC CULTURAL AND ETHNIC GROUPS

Goals and activities include:

- Maintain and analyze the penetration rates for underserved racial/ ethnic and cultural populations, twice a year.
- Monitor required annual Cultural Competency training. Goal: 80%, staff completion.
- Provide language services training to all DBH new employees to ensure clients receive services in their preferred language when accessing and receiving services. Goal: 100%.

This section of the departments QIPP is led by the Equity and Cultural Competency Officer. The Cultural Competency Workgroup meets bi-monthly to review the process of activities, identify barriers, and propose and implement solutions. See FY 2024/2025 Quality Improvement Plan Evaluation for more details on activities and accomplishments for FY 2024/2025.

DBH's Quality Improvement Performance Plan includes a section to monitor and assess quality of care. SECTION 11: CONSUMER/FAMILY MEMBER EVALUATION AND CONTRIBUTIONS

Goals and activities include:

- Increase SUDRS consumer and/or family member participation.
- Request consumers and family members identify, discuss, and implement quality improvement initiatives that can be made to the San Bernardino County Department of Behavioral Health system of care.

This section of the departments QIPP is led by the Consumers and Peer and Family Advocates. A The Consumer and Family Member Workgroup meets monthly to review the process of activities, identify barriers, and propose and implement solutions. See FY 2023/2024 Quality Improvement Plan Evaluation for more details on activities and accomplishments for FY 2023/2024. Quality Improvement Plan Evaluation for FY 2024/2025 was not available at time of submission.

Link to FY 2024/2025 Quality Improvement Performance Plan Quality Improvement Performance Plan FY 2024/2025
Link to FY 2023/2024 Quality Improvement Plan Evaluation Quality Improvement Performance Plan Evaluation FY 2023/2024. Quality Improvement Plan Evaluation for FY 2024/2025 was not available at time of submission.

8-IV-B: Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization's ability to value cultural diversity in its workforce and its culturally and linguistically competent services

In FY 2024/2025 the departments Department Diversity Committee received a budget of $10 thousand dollars to be used towards staff development and activities to promote diversity. Planning on the use of funds will take place in FY 2025/2026.

8-IV-C: Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

The DBH Grievance and Complaint process is threefold. Grievances and Complaints come through DBH's Access Call Center. The Access Call Center receives, logs, analyzes, and creates and maintains summary reports of all mental health and substance use disorder grievances received. This data is analyzed between departments. Summaries of the grievances are reviewed during Quality Management Action Committee (QMAC) meetings. Grievance and Appeal Policy and Procedures are in place and forms are located on the DBH Website https://wp.sbcounty.gov/dbh/consumerforms/.

Grievances can also come through the Patients' Rights Office for issues related more directly to Patients' Rights, as well as Inpatient Hospitalization issues. Patients' Rights currently logs and collects data regarding the nature of the grievance and the facility/program involved. Patients' Rights Policy and Processes are in place and forms are located on the DBH Website https://wp.sbcounty.gov/dbh/patientsrights/. A bi-annual grievance report is submitted to the department's Compliance Officer.

Additionally, DBH has a separate process for grievances related to Non-Discrimination-Section 1557 of the Affordable Care Act. Grievances are submitted to the ACA 1557 Coordinator who oversees the grievance process, including due process and prompt and equitable resolution of complaints and grievances from clients. Appeals of the decision made by the ACA 1557 Coordinator would be reviewed by the Equity and Cultural Competency Officer (ECCO) and appeals of the decision made by the Equity and Cultural Competency Officer would be reviewed by the DBH Director. Grievances that are received will be reviewed during the Cultural Competency Quality Improvement Workgroup meetings.

The CEC continues offering expertise in this capacity, in terms of what grievances they most often hear about and experience within their leadership roles at individual clubhouses. They also have been instrumental in brainstorming various strategies to ensure that consumers are aware of processes by which to submit grievances in the era of expanded use of telehealth when typical avenues of grievance submissions may not be as easily accessible. In FY 2022/2023, clubhouses began implementing their own process to acquire feedback from Clubhouse members regarding any changes or areas of improvement within their respective Clubhouse. All feedback is reviewed quarterly by the Consumer Evaluation Council (CEC) and decisions are made regarding whether to implement changes at the system level or refer to Clubhouse Staff or Consumer board for further review. This process continues in FY 2025/2026.

Cultural Competency Plan Update Fiscal Year 2024/2025 Attachment List